2024 – 2025 CityBasic Dependent Enrollment & "Opt Out" Form

SECTION I	**REQUIRED - COMPLETE THIS SECTION (Please Print)**			
SOCIAL SECURITY # or PERNR	DATE OF BIRTH	EMPLOYEE NAME (Last, First, MI)	☐ Single ☐ 2 party ☐ Family	SEX ☐ M ☐ F
ADDRESS	CITY	STATE	ZIP CODE	
HOME TELEPHONE NUMBER ( )	WORK TELEPHONE NUMBER ( )			
PERSONAL EMAIL	WORK EMAIL (if applicable)			

SECTION II IF YOU ARE ADDING DEPENDENTS – COMPLETE THIS SECTION (Please Print)

It is your responsibility to notify the Benefit Office when you have a change in family status during the plan year such as: **marriage, divorce, legal separation, termination of domestic partnership, birth, adoption, legal guardianship, changes to your spouses'/domestic partners' benefit program, death of an eligible dependent, and if a dependent child becomes ineligible due to age.** You must notify the Benefit Office of changes in your family status within 60 days of the change. Financial and/or eligibility penalties will apply should you fail to notify the Benefit Office within the 60-day timeline.

A. **Dependent Information:** *List all eligible dependents you wish to add to Health Plan Coverage in the spaces below*

1. Your lawful spouse or domestic partner may be covered. Please list on the first line below. Leave blank if you do not have a spouse or domestic partner.

2. Children(up to their 26th birthday) are defined as your children by birth or legal adoption (including placement prior to legal adoption), children related to you or your spouse/domestic partner by blood or marriage for whom you or your spouse/domestic partner are the legal (court-appointed) guardian and of whom you or your spouse/domestic partner has custody, spouse or domestic partner's children for whom your spouse is required by divorce decree or court order to provide health insurance, or for whom your spouse/domestic partner is primarily responsible for financial support. Children of your eligible dependent may be eligible so long as your dependent meets all eligibility requirements and is living with you. Children who obtain the age of 26 and are disabled may be eligible for continued coverage. The child may not be in active military service.

You MUST complete this section if you are requesting coverage for a spouse/domestic partner and/or eligible dependent children.

Social Security Number	First Name – Middle Initial – Last Name	Sex	Date of Birth	Relationship
				☐ Spouse ☐ Partner

SECTION III	**Premium Share (Cost to you per pay period)**		
CityBasic Medical with VSP Vision and Delta Dental	Single	Two Party	Family
	$16.47	$30.54	$43.94

SECTION IV AUTHORIZATION AND CERTIFICATE

PAYROLL DEDUCTION AUTHORIZATION: I authorize my employer, the City of Portland, to deduct from my wages, on a pay period basis, the amounts required to pay for my share of the cost of the employee benefits for 2 party or family coverage. (Deductions for 1 party coverage are automatically withheld.) I understand that these deductions will be made on a pre-tax basis as authorized by section 125 of the Internal Revenue Code.

Dated this _____ day of _____, 20__

Signature of employee:_____

CERTIFICATION OF UNDERSTANDING: I understand that any falsification, misrepresentation, misleading statements or omission may be cause for immediate termination from City benefit plans and I may be subject to discipline, including discharge, from City employment, regardless of when or how discovered. If a dependent or I fraudulently obtain any healthcare benefits under a City of Portland Health Plan, I and/or my dependent will be prosecuted to the full extent of the law. If I fail to report family status change events within 60 days of the date eligibility would cease, such as divorce or a dependent ceases to satisfy dependent eligibility requirements, it will be my obligation, and the obligation of anyone who assists me, to reimburse the City of Portland any monies which are paid by a City of Portland Health Plan for claims incurred. If a dependent or I fraudulently obtain any healthcare benefits under the City of Portland Health Plan, I and/or my dependent will be prosecuted to the full extent of the law.

Dated this _____ day of _____, 20__

Signature of employee:_____

SECTION V COMPLETE THIS SECTION IF YOU ARE OPTING-OUT OF COVERAGE

☐ I elect to opt out of Medical/Vision/Dental because I have other medical coverage (you must submit proof of other medical coverage to opt-out)

Please complete if you are enrolled under a group medical plan or you have other individual insurance:

I am currently enrolled in the following individual or group medical plan:

_____

Name of Insured Member: _____

Group Number: _____ Identification Number: _____

Are you or any eligible dependents listed on this enrollment form currently enrolled in Medicare coverage Part A and/or Part B?

☐ Yes ☐ No If Yes, list those with Medicare coverage

_____

Are you or any eligible dependents listed on this enrollment form eligible for Medicare Part A or Part B, but have declined coverage?

☐ Yes ☐ No If Yes, list those who declined Medicare coverage

_____

Submit your proof of other medical coverage to the Benefits Office with this opt-out form.

Please return this enrollment form via email to benefits@portlandoregon.gov or to the Benefit Office, Interoffice Address 106/987 or by mail to 1120 SW Fifth Avenue, Bureau of Human Resources, Room 987, Portland, OR 97204

If you have any questions, please call (503) 823-6031 or send an email to benefits@portlandoregon.gov.