2024 Addendum to Oregon Small Group Employee Enrollment/Change Form

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This form must accompany the Oregon Small Group Employee Enrollment/Change Form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Oregon Small Group Employee Enrollment/Change Form.

Employer section (To be completed by the employer. Subgroup and billgroup information required if coverage is selected.)

Company name[1] _____ Effective date of coverage[1] ____ / ____ / ____

Group #[1] _____ Medical subgroup # _____ Billgroup _____

Family dental subgroup #[1] _____ Billgroup _____

Pediatric only dental subgroup # (18 years and younger) _____ Billgroup _____

A Employee information *(Employee completes sections A, B, and C.)*

Legal name (last, first, MI)[1] _____ Former/maiden name (if any) _____

Date of birth[1] ____ / ____ / ____ Social Security # _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) _____

B Dependent information

Dependent (child) legal name (last, first, MI)[1,2] _____

Date of birth[1] ____ / ____ / ____ Social Security # _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) _____ Mobile phone _____ Disabled ☐ Yes ☐ No

☐ Medical

Dental (select one): ☐ Family dental ☐ Pediatric only dental (18 years and younger) ☐ Waiving pediatric dental[3]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy # _____ Medical record # (if any) _____

Dependent (child) legal name (last, first, MI)[1,2] _____

Date of birth[1] ____ / ____ / ____ Social Security # _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) _____ Mobile phone _____ Disabled ☐ Yes ☐ No

☐ Medical

Dental (select one): ☐ Family dental ☐ Pediatric only dental (18 years and younger) ☐ Waiving pediatric dental[3]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy # _____ Medical record # (if any) _____

☐ Check here if another Addendum to Oregon Small Group Employee Enrollment/Change Form is attached.

C Important

I understand it may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee signature[1] _____ Date ____ / ____ / ____

[1]Required

[2]Eligible through the last day of the month of their 26th birthday month or for dependent children over the age of 26 with a developmental disability, mental illness, or physical disability.

Per state law, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis. If your employer chooses to provide coverage for non-state registered domestic partners, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.

[3]By checking this box you are attesting that the member has pediatric dental coverage elsewhere that is compliant with the essential health benefits provision of the Affordable Care Act.