



SB 551 Member Enrollment

Office use only

Approved by: _____

Approved date: _____

Effective date: _____

Member information

Last name	First name	Middle	
E number or Social Security Number	Gender ☐ M ☐ F ☐ Other	Date of birth (mm/dd/yyyy)	
Home phone number	Work phone number	Cell phone number	
May OEBB send text messages to this number? Standard text message and data rates apply.		☐ Yes ☐ No	
Personal email	Work email		
Address	☐ Check if new address	Apartment or space#	
City	State	ZIP	County
Are you Medicare eligible? ☐ Yes ☐ No			
Are you serving or did you ever serve in the military?		☐ Yes ☐ No	
If "Yes," do you authorize OEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information?		☐ Yes ☐ No	
Ethnicity (Select one): ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown			
Race (Select at least one. If selecting more than one, circle one as primary): ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Refused ☐ Unknown			

Healthcare plan selections

Medical

Medical plan selection:

Write in plan selection.

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit if using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level regardless of whether or not the individual has chosen a PCP 360 with Moda. A list of PCP 360 providers can be found at: <https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml>

Vision

Vision plan selection:

Write in plan selection *(Must be enrolled in Kaiser Medical to enroll in Kaiser Vision)*

Dental

Dental plan selection:

Write in plan selection.

Member signature and authorization

I understand that these benefit elections will remain in effect for as long as I continue to meet the SB 551 eligibility or participation requirements as determined by my selected Home Institution.

I have read and understand OAR-Division 80, Sections 111-080-0040, 111-080-0045 and 111-080-0050 concerning Eligibility and Policy Term Violations and can find this OAR at: [Division 80](#)

I understand I have 31 days to notify my Home Institution of a Qualified Status Change (QSC) which affects eligibility. A full list of QSC's can be found at: <http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx>

I have read and understand OAR-Division 40 concerning Enrollment and can find this OAR at: [Division 40](#)

I have read the benefit materials and I understand the limitations and qualifications of the SB 551 benefits program.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This election supersedes all elections and submissions I previously made for SB 551 coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.

Member signature

Date

Submit this form to your Community College for SB 551 Coverage:

DO NOT SUBMIT TO OEBB