



Homecare Union Benefit Board Change Form



Complete this form to request an enrollment change.

Section A – Employee/Subscriber Information

- Complete all items in this section
- If making a change to your address only, complete Sections A and F and check the Address Only box in Section A
- If making a change to your name only, complete Sections A and F and check the Name Only box in Section A
- If making a change to other information in this section, complete Sections A and F and check the Other box in Section A and tell us what changed.

Section B – Enrollment Changes

- Check whether you are an Active participant or a COBRA participant
- Indicate the change you want to make.
- Check the Status Change Event that is causing you to make the enrollment change
- Enter the date of the Status Change Event

Section C – Medical and Dental Plan

- Complete this section only if you are changing medical and/or dental plans
- If you are changing to ODS Medical Plan, list your Primary Care Provider

Section D – Dependent Information

- List all dependents you want to cover on your plan. This form replaces all previous enrollment forms. Dependents not listed will not be covered.
- If you are deleting a dependent, do not enter their name on this form.
- If you are adding a dependent, enter their name on this form.
- Complete all of the information requested in this section.

Section E – Other Coverage Information

- Mark the yes or no box to indicate whether you or any enrolled dependents are covered through another medical or dental plan.
- If you marked yes, provide the requested information about the plan and if your other plan will be ending, provide the date coverage will end.

Section F – Employee/Subscriber Signature and Authorization

- Read this section carefully. Sign and date the form.
- Keep a copy of this form for your records.
- Send enrollment form to HUBB at the address below.

Homecare Union Benefit Board (HUBB), LLC PO Box 12159, Salem OR 97309-0159

Phone: (866) 364-4822 Fax: (503) 581-1664

www.hubbinsurance.org



SEIU Local 503, OPEU PO Box 12159, Salem, OR 97309-0159 Telephone: (503) 364-HUBB (4822) or (866) 364-HUBB (4822) Fax: (503) 581-1664

HUBB Change Form

Section A Employee/Subscriber Information

Change of: Name Only Address Only Other _____

Name (Last) _____ (First) _____ MI _____ | _____ - SSN - _____ | Provider No. _____

Home Address _____ City _____ | State _____ | Zip Code _____

Mailing Address (if different) _____ City _____ | State _____ | Zip Code _____

Residence County _____ Home Phone (_____) _____ | Work Phone (if available) (_____) _____

Birth Date ____/____/____ Gender M F | Email Address _____

Section B Enrollment Changes

I am: Active Participant COBRA Participant

I would like to:
 Add dependent(s)
 Delete dependents(s)
 Change medical and/or dental plan.

Status Change Event(s): (Please refer to information on the last page of this form)

- Move out of or into plan service area
- Employment Status Change
- Marriage/Domestic Partnership
- Birth, Adoption, Court Appointed Guardian
- Child Becomes Eligible or Ineligible for Coverage
- Loss of Other Group Coverage
- Divorce/Dissolve Domestic Partnership
- Enrolled on Other Coverage
- Medical Child Support Order
- Cost of Coverage Change
- Death
- Approval, denial or change in premium subsidies through FHIAP.

Status Change Date: _____ (examples: date you moved out of plan's service area, date other coverage ends)

Section C Medical and Dental Plan

Check the boxes indicating your new plan elections

- Kaiser Permanente Medical Plan
- Kaiser Permanente Dental Plan
- ODS Medical Plan
Primary Care Provider _____
- ODS Dental Plan

Section D Dependent Information

Family Relationship Key:

SP-Spouse

CH-employee or SP's child

DOCCH-child by documentation

DP-Domestic Partner

DPCH- DP's child

Name (Last, First,MI)	SSN	Birth Date	Gender	Relationship Key (Above)	Medical & Dental	Medical Only	Primary Care Physician
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
		/ /	M / F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Section E Other Coverage Information

Are you or any of your dependents covered through another group or individual plan?

Medical no yes (if yes, complete the following):

Dental no yes (if yes, complete the following):

Person(s) with other coverage _____

Insurance Company Name _____ Employer Name _____

Policy # _____ Group # _____ Effective Date _____ End Date _____

Are you or a dependent covered by Medicare or Veteran's Benefits? Yes No

Were you or any of your dependents covered through another group or individual plan at any time during the past 63 days before your enrollment date on this plan?

No

Yes, attach your Certificate of Creditable Coverage from your current or prior health plan. A preexisting period may be reduced by any prior creditable health coverage.

Section F Authorization

I understand and authorize:

My benefit elections, as indicated on this form, are in effect as long as eligibility requirements are met or until I elect to change them subject to provisions of the plan.

I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations and provisions of the HUBB insurance program. My signature further acknowledges that HUBB, FHIAP and the insurance carriers may request or disclose health information about me from time to time for the purpose of facilitating health care payment or treatment or for the purpose of business operations necessary to administer health care benefits. My signature authorizes HUBB, FHIAP and the State of Oregon, as applicable, to use my and the members of my family's Social Security Numbers (SSN) and to disclose my SSN to others as needed to confirm eligibility.

I hereby declare that the above statements are true to the best of my knowledge and I understand that false statements could jeopardize my eligibility and be subject to penalty for perjury.

This authorization will remain valid until I sign and submit a new Medical and Dental Enrollment Form or Change Form.

Employee Signature

Date

Enrollment Changes

Employees can make changes to their enrollment if the enrollment change request is consistent with and a result of a qualified status change as outlined below. Homecare workers requesting enrollment changes must submit the completed applicable forms to HUBB within 60 days of the status change date.

Status changes include:

- You marry or establish a domestic partnership through affidavit
- Your spouse or domestic partner dies; or you divorce or dissolve your domestic partnership
- Your biological child is born, you adopt a child or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your employment status changes
- Your spouse's or domestic partner's employment status changes
- The cost of your benefit coverage changes
- You, your spouse or domestic partner, or dependent child loses other benefit coverage
- You, your spouse or domestic partner receives a national medical support order
- You, your spouse or domestic partner moves out of the plan's service area.
- Your family member is approved or denied for a FHIAP premium subsidy, or the amount of your FHIAP premium subsidy changes through FHIAP.

An enrollment change is consistent with a change in status if the change results in the employee, spouse, domestic partner or dependent child gaining or losing eligibility for coverage under the plan or a plan of the spouse, domestic partner, or dependent child's employer. The enrollment change must correspond with the gain or loss of coverage. An individual who becomes eligible or ineligible for a particular plan (such as moving out of a plan's service area) is treated as gaining or losing eligibility for coverage under the plan.



www.hubbinsurance.org

HUBB Benefit Specialists are available by telephone Monday through Friday, 8 a.m. to 5 p.m. Do not hesitate to give them a call with your questions about the HUBB Insurance Program.

Location

1730 Commercial St SE

Hours of Operation

8:00 am - 5:00 pm
Monday - Friday

Mailing Address

PO Box 12159
Salem, OR 97309-0159

Email

HUBB@opeuseiu.org

Phone

(503) 364-HUBB (4822)
Toll free: (866) 364-4822
Fax: (503) 581-1664