



500 Summer Street NE, E-88
Salem, OR 97301-1063
Toll-free (Benefits) 888-469-6322
Email: oebb.benefits@oregon.gov

MyOEBB Rules Selection Form

OEBB needs to set up rules specific to your Employing Entity in order for your employees to accurately enroll in benefits. OEBB needs to have this form completed and turned in to OEBB as agreed upon by your Employing Entity and OEBB. OEBB will apply the OEBB OAR's as rules for your Employing Entity if we do not get this form back. Please note your Employing Entity will be unable to change these rules until the next plan year.

Entity Name: _____

Entity Institution Number (if applicable): _____

1. Does your Entity allow coverage to include opposite sex domestic partners?
(Please circle one selection)

Yes No

2. Does your Entity need access to the Coverage Effective Start Date field, or will benefits always start the first of the next month after the date of hire or the first of the month after which the employee enrolls online?
For example, you have an employee that starts employment on May 15th, their benefits would start on June 1st if they enroll online by May 31st, or benefits would start on July 1st if they enroll on June 2nd.
(Please circle one selection)

Yes, we need access to the Coverage Effective Start Date

No, our Coverage Effective Start Date will follow the OEBB OAR's

3. Does your Entity offer optional benefits to employees that do not qualify for healthcare benefits?

Yes, our Entity offers optional plans to non-healthcare eligible employees and would like to continue this. *(If yes, please fill out info for employment/member type groups on next page.)*

No, our Entity does not offer optional plans to non-healthcare eligible employees.

Employment Type

Member Type

- a) _____
- b) _____
- c) _____

4. Does your Entity want the OEGB full premium to display for members on their personal benefit statement?
(Please circle one selection)

Yes No

5. Does your Entity allow Early Retirees or their dependents over the age of 65 to remain on an Entity dental plan only?
(Please circle one selection)

Yes No

Entity Official Signature: _____

Printed Name: _____

Position: _____

Date Signed: _____

*Please **fax** your Rules Selection Form to the following contact:*

Dawn Wrezinski, Benefits Analyst
Fax: (503) 378-5832

*Then, **mail the original** to the following address:*

Oregon Educators Benefit Board
Attn: Dawn Wrezinski/Rules Selection Form
500 Summer Street NE, E-88
Salem, OR 97301-1063