Wellness Clinic Enrollment Form

Serving Benefits-Eligible 4J Employees, Retirees and Their Dependents

Effective Date: ☐☐-☐☐-☐☐☐☐ **Employee #:** ☐☐☐☐☐☐

Employee Name: _____
(First) (Middle Initial) (Last)

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*Dependent Information**

Please list dependents who are eligible for the 4J health insurance plan, but not enrolled.

Dependent 1: _____
(First) (Middle Initial) (Last)

Date of Birth: ☐☐-☐☐-☐☐☐☐ SSN: ☐☐☐-☐☐-☐☐☐☐

Relationship: ☐ Spouse ☐ Partner ☐ Child ☐ Stepchild ☐ Partner's Child ☐ Ward

Gender: ☐ Male ☐ Female

Dependent 2: _____
(First) (Middle Initial) (Last)

Date of Birth: ☐☐-☐☐-☐☐☐☐ SSN: ☐☐☐-☐☐-☐☐☐☐

Relationship: ☐ Spouse ☐ Partner ☐ Child ☐ Stepchild ☐ Partner's Child ☐ Ward

Gender: ☐ Male ☐ Female

Dependent 3: _____
(First) (Middle Initial) (Last)

Date of Birth: ☐☐-☐☐-☐☐☐☐ SSN: ☐☐☐-☐☐-☐☐☐☐

Relationship: ☐ Spouse ☐ Partner ☐ Child ☐ Stepchild ☐ Partner's Child ☐ Ward

Gender: ☐ Male ☐ Female

Dependent 4: _____
(First) (Middle Initial) (Last)

Date of Birth: ☐☐-☐☐-☐☐☐☐ SSN: ☐☐☐-☐☐-☐☐☐☐

Relationship: ☐ Spouse ☐ Partner ☐ Child ☐ Stepchild ☐ Partner's Child ☐ Ward

Gender: ☐ Male ☐ Female

If more than four dependents are to be listed, please submit additional form(s).

X _____ X _____

Employee Signature **Date Signed**

*For the definition of benefits-eligible dependent, please visit the OEBB web site: http://www.oregon.gov/oha/OEBB/Pages/DEVReq.aspx

REV.03-24-2014.