Oregon TECH
Human Resources

Employee Leave Checklist
Maternity Leave
Employee's Own Serious Health Condition (pregnancy) and Parental Leave

Maternity Leave is a combination of leave for an Employee's Own Serious Health Condition and Parental Leave to bond with a newborn. You may be eligible for leave under the Family Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA) and Oregon Paid Family Medical Leave (PFML). These leaves entitle eligible employees up to 24 weeks of FMLA/OFLA leave. This includes up to 12 weeks of leave (not common, typical is 6-8 weeks) in a 12-month period for your own Serious Health Condition (pregnancy and recovery), in addition you may take up to 12 weeks under OFLA for parental leave. FMLA/OFLA/PFML protects your job and benefits. The typical maternity leave without complications is 18 weeks. This leave is paid by Paid Leave Oregon for a maximum of 14 weeks; remaining time is not paid leave unless you have sick and/or vacation time to use. If you have Short Term Disability Insurance, you may be eligible to use the wage replacement benefits it provides during the period of your own Serious Health Condition.

STEP 1: INFORMATION TO READ AND REVIEW

- ◻ FMLA Employee Rights Notice
- ◻ OFLA Employee Rights Notice
- ◻ OIT Notice of Employee Rights

STEP 2: COMPLETE LEAVE REQUEST FORM

- ◻ FMLA/OFLA Leave Request Form – complete and return to HR

STEP 3: MEDICAL CERTIFICATION

- ◻ Medical Certification – give to Medical provider and have them return to HR

STEP 4: LEAVE AND LEAVE BENEFITS

- ◻ If you are located in the State of Oregon and/or if you have Short Term Disability via PEBB
    - Contact The Standard at 1-800-242-1888 (PFML Policy #762196)
- ◻ Complete your FMLA/OFLA Attendance Record/Leave Tracking Form and your Employee Leave slip every month

STEP 5: BENEFITS CHANGES (if you want to add new child to your benefits)

- ◻ Mid-Year Change Form - submit to HR within 30 days. Attach a copy of the birth record.
- ◻ Open Enrollment Correction Form - For babies born after Open Enrollment ONLY

STEP 6: LACTATION ACCOMMODATIONS

- ◻ Notify HR if you need accommodations prior to your return. HR will provide you key access and additional information on the current designated spaces.

STEP 7: RETURN TO WORK

- ◻ Notify HR at the time of your return

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

OREGON FAMILY LEAVE

You can take time off for pregnancy disability, bereavement or to provide home care for your child under the Oregon Family Leave Act (OFLA).

- **This time is protected, but often unpaid unless you have vacation, sick, or other paid leave available.** However, while on OFLA leave, your employer must let you use any vacation, sick, or other paid leave you have accrued. OFLA leaves are separate from Paid Leave Oregon benefits.
- OFLA applies to employers with 25 or more employees.
- To be eligible, you must have worked an average of 25 hours per week for 180 days. A separation from employment or removal from the schedule for up to 180 days does not count against eligibility. (During a public health emergency, eligibility starts at just 30 days working 25 or more hours per week.)
- You can take up to 12 weeks of time off per year for:
  - **Providing care to your child related to an illness, injury or conditions that requires home care** or when your child's school or child care provider is closed as a result of a public health emergency.
  - **Bereavement** (up to two weeks) for the death of an individual related by blood or affinity.
  - Through 2024, you can also take up to two additional weeks for the legal process required for foster child placement or adoption.
  - **Pregnancy disability leave** In addition to leave for the other reasons listed here, you can take up to 12 additional weeks of time off per year for pregnancy disability before or after the birth of child or for prenatal care.
- Your employer must keep giving you the same health insurance benefits as when you are working. When you come back you must be returned to your former job or a similar position if your old job no longer exists.
- Military family leave (up to 14 days) is also available if your spouse is a service member who has been called to active duty or is on leave from active duty.

CONTACT US

If your employer isn't following the law or something feels wrong, give us a call. The Bureau of Labor and Industries is here to enforce these laws and protect you.

Call: 971-245-3844
Email: BOLI_help@boli.oregon.gov
Web: oregon.gov/boli
Se habla español.

OREGON LAWS
Protect You At Work
July 2024 - June 2025

Oregon TECH
Human Resources

Notice of Employee Rights and Responsibilities FMLA/OFLA Leave

If your leave qualifies for FMLA, OFLA, or PFML leave, you will have the following rights and responsibilities:

Leave Entitlement: Effective the first day of your leave, time taken under the protected leave laws is counted against your leave entitlement. Generally, you are entitled to 12 weeks of protected leave in a rolling forward 12-month period. The rolling 12-month period is measured forward from the Sunday proceeding the date of any protected leave usage. Some leave types may be entitled to additional protected leave.

Paid Leave: You will be required to use your paid accruals (sick, vacation, etc.) during your FMLA/OFLA leave unless you are receiving the benefits of PFML, or short- or long-term disability. This means you will use your paid leave (sick, vacation, etc.) and that such leave will also be considered protected under the FMLA/OFLA leave and counted against your protected leave entitlement.

- All Employees must use available accrued sick leave during FMLA/OFLA leave, unless the employee is on approved FMLA and is utilizing his/her short-term disability benefit, long-term disability benefits, or the benefits of PFML.

- Classified Employees: Classified employees must use all accrued vacation leave during FMLA/OFLA leave before going into unpaid status (leave without pay), unless the employee is on approved FMLA, OFLA, and/or PFML and is utilizing short-term disability benefits, long-term disability benefits, or the benefits of PFML. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 47-Vacation Leave, Section 14, regarding an employee's option to retain up to 40 hours of accrued vacation leave.

  Upon exhausting all accrued sick leave, classified employees may use accrued vacation leave, compensatory/exchange time, and/or personal leave during FMLA/OFLA/PFML leave.

  After exhausting all paid leave, classified employees may request hardship leave donations. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 40 – Sick Leave, Section 8.

- Unclassified Administrative Employees: Upon exhausting all accrued sick leave, unclassified employees may use accrued vacation leave time during FMLA, OFLA, and/or PFML leave before going into unpaid status (leave without pay). You may also elect to retain up to 40 hours of accrued vacation leave as described in the policy.

- Faculty: Upon exhausting all accrued sick leave, unclassified employees may use accrued vacation leave time during FMLA/OFLA/PFML leave before going into unpaid status (leave without pay).

- Employees may not go in and out of unpaid status, unless on approved FMLA/OFLA and receiving short-term or long-term disability benefits through Standard Insurance, or the benefits of Paid Leave Oregon.

Benefits: Approved FMLA, OFLA, and PFML Leaves: Your health insurance coverage will continue provided you continue to contribute your portion of the premiums. Premiums will be deducted through normal payroll deduction when available. An employee who is in leave without pay status during FMLA, OFLA, or PFML leave will be responsible to self-pay their portion of health insurance premiums directly to the University. Employee paid optional benefit premiums may be also be continued when self-paid by the employee.

If you do not return to work following FMLA and/or OFLA leave you may be required to reimburse the University for the employer share of health insurance premiums paid on your behalf during your leave.

Medical Certification: In order to determine whether an employee's absence qualifies for protected leave under the FMLA and OFLA leave laws, you may be required to provide a medical certification from a qualified health care provider within 15 calendar days of the receipt of your notice for eligibility to take protected leave. It is the employees' responsibility to ensure a complete and sufficient medical certification is returned to Human Resources within the designated timeframe. When utilizing the benefits of PFML medical certification will also be required to support your claim, The Standard will provide you with the required paperwork for this.

While on approved FMLA or OFLA leave, you may be required to provide additional medical certifications if requested by Human Resources. The interval between re-certifying will not be less than 30 days, unless the circumstances for your leave have changed significantly.

Failure to provide a complete and sufficient Medical Certification may result in your leave being denied. Denied FMLA and/or OFLA is not protected under the leave statutes and the University may treat the absences as unexcused.

Periodic Check In: While on leave, you are required to check in periodically with Human Resources. You should provide information on your status, any change in circumstances, and if out for a continuous block of time, your intent to return work.

Status Changes: You are required to notify Human Resources if the status of your leave requirements changes. Status changes may include, but are not limited to: a need for continuous leave while on approved intermittent leave; a need for more intermittent leave than the amount currently approved; or a need for leave beyond the current approved end date. If you are on approved leave and no longer require time off for the approved reason, please contact Human Resources to close your file.

Leave Reporting: You are required to record any FMLA/OFLA/PFML leave taken on a leave tracking form which should be provided to Human Resources monthly, typically by the 5th of the following month.

Return to Work: If the status of your situation changes and you do not anticipate returning on your scheduled return date, you are expected to notify your supervisor and the Human Resources office as soon as possible.

When you return, you must be able to carry out the essential functions of your position. If your leave was for your own Serious Health Condition, you will be required to provide either a Return to Work form or a medical certification stating you are able to return to work without restrictions. If there are restrictions associated with your return to work, please contact Human Resources, so those restrictions can be reviewed and evaluated to determine if we are able to provide Reasonable Accommodations on a temporary basis.

Reinstatement Rights: Upon returning from protected leave, you have the following reinstatement rights:

- FMLA: You must be reinstated to either the same position held when leave began or to an equivalent position. An equivalent position is one that is virtually the same as the employee's former position in terms of pay, benefits, and working conditions and must involve the same or substantially similar duties and responsibilities.
- OFLA/PFML: You must be reinstated to the position held when the leave began.

If you remain on leave after exhausting your protected leave entitlement (FMLA, OFLA, and/or PFML), you will not have the reinstatement rights outlined above.

For additional information pertaining to leave, contact Human Resources at 541-885-1028.

Oregon TECH
Human Resources

Leave of Absence Request Form

EMPLOYEE INFORMATION			
Name:		**ID#:**	
Department:		**Job Title:**	
Employee Type:	☐ Classified ☐ Faculty	☐ Unclassified Admin	☐ Student Employee
Supervisor Name:			
Contact information while on leave			
Personal Email:			
Mailing Address:			
Phone:			

LEAVE INFORMATION

I am requesting a leave of absence for the following reason:

- ☐ My own serious health condition
- ☐ Birth of my child, and/or to care for the newborn child or placement of a child for adoption/foster care
- ☐ My child's NON-SERIOUS health condition
- ☐ To care for my family member with a serious health condition
- ☐ Qualifying military exigency leave
- ☐ Service member care leave (SMCL)
- ☐ Bereavement leave

If applicable, please specify the person the leave is for and the relationship:

Name:	
Relationship:	

Is the condition due to an on-the-job injury or illness?	☐ Yes	☐ No	☐ N/A

I am requesting a leave of absence with the following schedule *(MM/DD/YYYY)*:

❒ Full-time leave from		to	
❒ Intermittent leave from		to	
❒ Reduced-schedule leave from		to	

Describe proposed intermittent or reduced schedule:

COMPENSATION DURING LEAVE

Will you be applying for Short Term Disability (STD)?	☐ Yes	☐ No	☐ N/A
Will you be using leave during any STD waiting period?	☐ Yes	☐ No	☐ N/A
Will you be using leave to supplement your STD payment?	☐ Yes	☐ No	☐ N/A
Will you be applying for Paid Family Medical Leave (PFML)?	☐ Yes	☐ No	☐ N/A
Will you be using leave to supplement you PFML payment?	☐ Yes	☐ No	☐ N/A

Please list the types of leaves you wish to use in sequence

Type of Leave	1st	2nd	3rd	4th	5th	N/A
Leave without Pay	☐	☐	☐	☐	☐	☐
Sick Leave	☐	☐	☐	☐	☐	☐
Vacation	☐	☐	☐	☐	☐	☐
Compensatory/Exchange Time (Classified Only)	☐	☐	☐	☐	☐	☐
Personal Days (Classified Only)	☐	☐	☐	☐	☐	☐

Use my special day on:	
I will use paid holidays on:	

I wish to retain ______ hours of vacation *(classified & unclassified admin only, 40 hours max)*

________________________________ ____________________

Employee Signature **Date**

Oregon and Federal
Family and Medical Leave
Health Care Provider Certification

This form is to be completed by physician or other health care provider and returned to:
☐ the employee, or ☐ the employer (below):

Information sought on this form relates only to the condition for which the employee is taking leave.

Employee's Name: ____

Patient's Name (if different from employee)**:** ____

1. On the reverse of this sheet is a description of various "serious health condition" categories that qualify under the Family and Medical Leave Acts. Please check appropriate category or categories:

☐ 1-Hospital care ☐ 3-Pregnancy and/or prenatal care ☐ 5-Perm/long-term condition requiring supervision
☐ 2-Absence plus treatment ☐ 4-Chronic condition requiring treatment ☐ 6-Multiple treatments (non-chronic condition)

2. Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category: ____

____

3. Approximate date condition began and probable duration: from __/__/__ through __ /__/__

4. Probable duration of patient's present incapacity (if different): from ___/___/___ through __ /___/___

5. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?

☐ Yes ☐ No If yes, duration and frequency of episodes of incapacity: ______________________________

6. Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment? ☐ Yes ☐ No If yes, duration: ______________________

Frequency: ☐ One to two days per month ☐ Two to three days per month ☐ Three to four days per month

☐ Other: Please explain how the employee will use leave intermittently or work a less than full-time schedule, being as specific as possible including frequency and duration of absences:

____

7. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see reverse side for definition)? ______________________

____

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment? ________________

What is the duration of each treatment and any period required for recovery? ______________________________

8. If this certification relates to the employee's seriously ill family member(s), also complete the following:

a. Does the patient require assistance for basic medical or personal needs, safety, or for transportation? ☐ Yes ☐ No

b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ Yes ☐ No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: ____

______________________________ ______________________________
Printed Name of Physician/ Practitioner *Date Signed*

______________________________ ______________________________
Signature of Physician/ Practitioner *Type of Practice/ Field of Specialization*

______________________________ ______________________________
Address *Phone Number*

Definition of a "Serious Health Condition":

A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one of the following:

1. Hospital care –
Inpatient care (i.e., overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence plus treatment –
A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

(a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider, ***or***

(b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

(1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.

(2) A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment DOES NOT include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.

3. Pregnancy –
Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

4. Chronic conditions requiring treatments –
A chronic serious health condition is one which:

(a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/ long-term conditions requiring supervision –
A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

6. Multiple treatments (non-chronic conditions) –
Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Definition of "Incapacitated": Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Directions regarding "Regimen of treatment" (question 5): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.

Reporting an Absence

Oregon Paid Family and Medical Leave

WHEN SHOULD I REPORT AN ABSENCE?

You should report an absence to Standard Insurance Company (The Standard‡) if you're absent from work or know you'll be absent from work for any of the following reasons:

- **Your own serious health condition, including pregnancy**
- **Bonding with a child in the first 12 months after birth, adoption or foster care placement**
- **Caring for a qualifying family member with a serious health condition**
- **Safe leave for those experiencing or managing the impacts of family violence**

HOW SHOULD I REPORT AN ABSENCE?

Contact The Standard's Services Center at:
800.242.1888

Please reference the following:
Oregon Institute of Technology | Policy# 762196

Remember to stay in contact with both us and your employer throughout your leave.

WHAT ARE THE CENTER'S HOURS OF OPERATION?

Monday through Friday
5 a.m. – 5 p.m. Pacific

WHAT ABOUT OTHER TIMES I'LL BE OUT?

For all other absences, please follow your typical department process. If you have questions, contact the Office of Human Resources.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company. Oregon Paid Family and Medical Leave Insurance underwritten by Standard Insurance Company is provided under policy form numbers: OR0923-PFML, OR0923-PFML-ENHANCEMENTS

OR PFML Admin Poster - AMS & TCI
OR-Template
(4/23)

SI **23070**

Oregon TECH
Human Resources

FMLA/OFLA ATTENDANCE RECORD / LEAVE TRACKING FORM

Name: ______________________
Department: ______________________
Employee ID#: ______________________
Instructions: Please record the number of hours you were off each day while on FMLA/OFLA leave. Include holidays.
Do not include days you would not have been expected to be at work (your normal days off).
Return this form at the end of each month.

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Jan																																	
Feb																																	
Mar																																	
Apr																																	
May																																	
Jun																																	
Jul																																	
Aug																																	
Sep																																	
Oct																																	
Nov																																	
Dec																																	

Employee's Signature: ______________________
Date: ______________________

Supervisor's Signature: ______________________
Date: ______________________

Public Employees' Benefit Board

Midyear Change Form

Qualified Status Change (QSC)

Office use only
Approved by: ________________
Approved date: ________________
Effective date: ________________

See the Summary Plan Description and the QSC Matrix at www.pebbinfo.com.

Section 1: Employee information

PEBB benefit number (P########), OR#, University ID or Lottery ID		Gender ☐ M ☐ F ☐ Other	
Last name	First name	M.I.	
Date of birth (mm/dd/yyyy)			
☐ Check if new address			
Address		Apartment or space#	
City	State	ZIP	County
Work phone number	Cell phone number (Optional)	Email (Optional)	

Are you Medicare eligible? ☐ Yes ☐ No

Are you serving or did you ever serve in the military? ☐ Yes ☐ No

If "Yes," do you authorize PEBB 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):

☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

☐ White ☐ Other ☐ Refused ☐ Unknown

Section 2: What changed?

See the QSC Matrix at www.pebbinfo.com under Resources. The event date must be included below.
Dependent = Eligible Spouse, Domestic Partner or child.

☐ Marriage	Date
☐ Divorce or annulment	Date
☐ Addition of a domestic partnership (Include Domestic Partnership by Affidavit Form)	Date:
☐ Termination of domestic partnership	Date:
☐ Birth	Date:
☐ Adoption or placement for adoption (legal documentation required)	Date:
☐ Addition of a Child/Grandchild by Affidavit (Include appropriate PEBB Affidavit Form)	Date:
☐ Termination of a Child/Grandchild by Affidavit (Include appropriate PEBB Affidavit Form)	Date:
☐ Employee gains other group coverage	Date:
☐ Dependent gains other medical group coverage	Date:
☐ Employee loses other medical group coverage	Date:
☐ Dependent loses other medical group coverage	Date:
☐ Employment status change (describe)	Date:
☐ Death of a dependent or spouse	Date:
☐ National Medical Support Notice (NMSN)	Date:
☐ Move out of current plan's services area	Date:
Tobacco midyear change info (Self): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:
Tobacco midyear change info (Spouse/Domestic Partner): ☐ Quit ☐ Never used ☐ Medical provider advised not to quit (medical condition) ☐ Used tobacco in previous 12 months ☐ Have not used tobacco products in the previous 12 months	Date:

Section 3: Dependent information

1. List all eligible family members you want to provide coverage for. Attach additional dependent sheets if necessary.
2. Required affidavits and legal documents for a Domestic Partner, Child, or Grandchild by Affidavit must be submitted no later than 5 business days from sumbitting this enrollment form.
    - Note: HR/Payroll offices will not begin benefits for these dependent(s) until all documenation has been given to HR/Payroll. Necessary affidavits are available at at www.pebbinfo.com.
3. Domestic Partner by Certificate does not require proof of certificate to HR/Payroll.
4. If you are terminating coverage for a dependent you MUST provide an address below for mailing of required COBRA notices.

For more information, visit Oregon's Administrative Rule (101-015-0011) concerning eligible Dependents by Affidavit: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6

Dependent A ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic Partner by Certificate ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's Child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth (mm/dd/yyyy) | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address (if different from employee address) | City | State | ZIP

Ethnicity (Select one) ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (Select at least one)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent B ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic Partner by Certificate ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's Child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth (mm/dd/yyyy) | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address (if different from employee address) | City | State | ZIP

Ethnicity (Select one) ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (Select at least one)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent C ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic Partner by Certificate ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's Child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth (mm/dd/yyyy) | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address (if different from employee address) | City | State | ZIP

Ethnicity (Select one) ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (Select at least one)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent D ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic Partner by Certificate ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's Child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth (mm/dd/yyyy) | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address (if different from employee address) | City | State | ZIP

Ethnicity (Select one) ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (Select at least one)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Dependent E ☐ Terminate coverage Enroll: ☐ Medical ☐ Vision ☐ Dental

☐ Spouse ☐ Domestic Partner by Certificate ☐ Domestic Partner by Affidavit ☐ Child
☐ Step Child ☐ Partner's Child ☐ Grandchild by Affidavit (OAR 101-015-0011) ☐ Child by Affidavit (OAR 101-015-0011)

Gender ☐ M ☐ F ☐ Other | Date of birth (mm/dd/yyyy) | Medicare eligible? ☐ Y ☐ N

Last name | First name | Middle

Address (if different from employee address) | City | State | ZIP

Ethnicity (Select one) ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Refused ☐ Unknown

Race (Select at least one)
☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other ☐ Refused ☐ Unknown

Section 4: Healthcare plan selections

A: Choosing not to enroll in a PEBB medical plan, select one of the following options:

☐ **OPT-OUT**

Opting Out of a medical enrollment is conditioned upon my understanding and attesting that the following statements are true:

- I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer-sponsored medical plan for the taxable year 2023. You do not need to provide proof of alternative medical coverage. See information at https://www.oregon.gov/oha/PEBB/Documents/Opt-out-Decline.pdf.
    1. The following coverages are not eligible to Opt-Out against Oregon Health Plan/Medicaid, Student Health, and individual market coverage.
- I understand my employer will not pay the monthly Opt-Out payment to me if my employer knows or has reason to know that I or any other member of my expected tax family does not have or will not have the alternative coverage.
- I understand that I must renew this attestation each plan year and applicable tax year for which I want the Opt-Out to apply.

By checking the Opt-Out box, and signing the form I verify the above statements are true.

☐ **Decline**

Select this option if you wish to decline all PEBB benefits. If you decline core benefits (medical/dental/vision/employee basic life), you're choosing to not participate in any of the PEBB programs. You will not receive cash in lieu of the medical coverage and you are not eligible to enroll in any PEBB plans.

B: Medical

If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 for that individual to receive the "in-network" benefit. If an individual has not chosen a PCP 360 with Moda, they will receive the "out-of-network" level benefits. A list of PCP 360 providers can be found at: https://www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml

Medical plan selection:	Full-time	Part-time
Kaiser Deductible (Kaiser vision included with full-time plan)	☐	☐
Kaiser Traditional (HMO) (Kaiser vision included with full-time plan)	☐	☐
Moda Synergy	☐	☐
Providence Statewide	☐	☐
Providence Choice	☐	☐

Full-time employees may only enroll in full-time plans. Part-time employees can enroll in either full-time or part-time plans. If a part-time employee enrolls in full-time plan, the part-time employee will not receive the part-time subsidy.

C: Dental plan selection:	Full-time	Part-time
Kaiser Permanente Dental	☐	☐
Delta Dental Premier	☐	☐
Delta Dental PPO	☐	N/A
Willamette Dental Group	☐	N/A

☐ I decline dental enrollment

D: Vision plan selection:

- ☐ VSP Basic Plan
- ☐ VSP Plus — Includes the Basic Plan and PLUS additional benefits
- ☐ I decline VSP enrollment

Section 5: Double coverage surcharge

Are any of your covered family members offered medical insurance as an employee through OEBB or PEBB?	☐ Yes ☐ No
Are they enrolled in the OEBB or PEBB medical insurance offered? (If you answered yes to both questions, a $5 per month surcharge will be applied to your premium.)	☐ Yes ☐ No

Section 6: Tobacco usage

If you enroll in a Medical plan and do not complete this Section, a tobacco surcharge ($25 per employee and $25 for spouse/domestic partner enrolled in medical) will be deducted each month from your pay.

Check one box:

- ☐ I currently use tobacco, but my spouse/domestic partner currently does not use tobacco. ($25)
- ☐ I currently do not use tobacco, but my spouse/domestic partner currently uses tobacco. ($25)
- ☐ Both my spouse/domestic partner and I currently use tobacco. ($50)
- ☐ Both my spouse/domestic partner and I currently do not use tobacco. ($0)
- ☐ I currently use tobacco, and do not have a spouse/domestic partner covered by PEBB. ($25)
- ☐ I currently do not use tobacco, and do not have a spouse/domestic partner covered by PEBB. ($0)
- ☐ I do not enroll in PEBB medical plans.
- ☐ My or ☐ My spouse's or domestic partner's provider advised not to quit using tobacco (Medical Waiver). ($0)

Section 7: Other employer group coverage

When your spouse or domestic partner is enrolled in your PEBB medical coverage and has access to other group medical coverage (not a PEBB medical plan) from their employer's sponsored group plan, but does not enroll in it, $50 will be deducted from your monthly pay.

Check one box:

- ☐ My spouse/domestic partner has PEBB coverage as an eligible employee (includes a spouse who enrolls in Opt-Out). ($0)
- ☐ My spouse/domestic partner has other employer group coverage, (not PEBB coverage) and enrolls for that coverage. ($0)
- ☐ My spouse/domestic partner has other employer group coverage available, (not PEBB coverage) but does not enroll in that coverage, and is enrolled in PEBB coverage. ($50)
- ☐ My spouse/domestic partner does not have other employer group coverage available. ($0)
- ☐ I do not cover a spouse or domestic partner in a PEBB medical plan. ($0)

Section 8: Optional plans

A: Optional life insurance

As a newly eligible employee for your first time enrollment, the Optional Employee Life has a guaranteed issue enrollment amount of up to $100,000 and Optional Spouse/Domestic Partner Life has a guaranteed issue enrollment amount of up to $20,000 without needing to submit a medical history to The Standard underwriting for approval.

You can find a link to the Medical History Statement on the PEBB website at:
http://www.oregon.gov/oha/PEBB/Pages/Forms.aspx

**Guaranteed issue means medical history is not required. If an initial request is made with a Qualified Status Change (QSC), guaranteed issue amount is applicable. You are required to submit a medical history statement on any coverage amount that is over guaranteed issue.

Employee optional life insurance

☐ Cancel coverage

Add or Reduce

New hire/Newly eligible enrollment $ ____________ ($20,000 increments up to $100,000)

Additional requested amount above guaranteed issue** $ ____________ ($20,000 increments up to $500,000)

Total requested amount $ ____________ ($600,000 maximum)

Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply.)
☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

B: Spouse/Domestic Partner optional life insurance

☐ Cancel coverage

Add or Reduce

New hire/Newly eligible enrollment $ ____________ ($20,000)

Additional requested amount above guaranteed issue** $ ____________ ($20,000 increments up to $380,000)

Total requested amount $ ____________ ($400,000 maximum)

Required: Tobacco use status, check one

☐ Spouse/domestic partner has used tobacco products in the previous 12 months. (Tobacco premium rates apply.)
☐ Spouse/domestic partner has not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

C: Dependent life insurance

Provides $5,000 of coverage for each of your PEBB eligible dependent(s) (including spouse or domestic partner).
See rates at www.pebbinfo.com

☐ Cancel coverage

☐ Enroll in coverage

D. Accidental death & dismemberment (AD&D) insurance

☐ **Employee only** ☐ Cancel coverage

Total requested amount $______________________________ ($50,000 increments up to $500,000 maximum)

Medical history is not required.

Or

☐ **Employee and dependent optional AD&D** ☐ Cancel coverage

Total requested amount $______________________________ ($50,000 increments up to $500,000 maximum)

Medical history is not required.

E. Disability insurance

Monthly premium is calculated on a percentage of your basic monthly salary. Benefits may replace a portion of salary when the employee has a qualified disability claim.

Short-term disability

Short-term disability plans pay weekly benefits with coverage dates depending upon plan enrollment.

☐ Enroll in coverage ☐ Cancel coverage

Long-term disability

Long-term disability plans pay monthly benefits starting after 90 or 180 day waiting period depending upon plan enrollment.

☐ Enroll or change coverage ☐ Cancel coverage

- ☐ After 90 day plan pays 60%
- ☐ After 90 day plan pays 66-2/3%
- ☐ After 180 day plan pays 60%
- ☐ After 180 day plan pays 66-2/3%

F. Long-term care insurance

To enroll for Long-Term Care (LTC) insurance complete a Unum Enrollment Form at:
https://www.oregon.gov/OHA/PEBB/Pages/forms.aspx
For more information, please visit:
https://www.oregon.gov/oha/pebb/Pages/Long-Term-Care.aspx

Section 9: Beneficiary designation

I elect:

☐ The Standard Order of Survivorship. (If you have a Domestic Partner, an Affidavit must be on file for distribution.)

☐ To designate the following beneficiaries. (Attach additional sheets if necessary.)

Total of primary percentages must = 100% **Total of contingent percentages must = 100%**

Name			Address		
City	State	ZIP	Relationship	Primary or contingent ☐ OR ☐	Whole %
Name			Address		
City	State	ZIP	Relationship	Primary or contingent ☐ OR ☐	Whole %
Name			Address		
City	State	ZIP	Relationship	Primary or contingent ☐ OR ☐	Whole %

Section 10: Employee signature and authorization

I declare the dependents listed and I are eligible for the coverages requested per Oregon Administrative Rule (OAR) Division 15. I have read the benefit materials, and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments to be deducted from my pay.

I understand that:

- The benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan.
- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to penalty for false claims including, but not limited to: termination of enrollment, denial of future enrollment, civil damages, imprisonment and fines.
- If I fail to report a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.
- You must submit a midyear change form to your payroll office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries may lose the right to elect COBRA.
- This form supersedes all forms and submissions I have previously made regarding PEBB coverage for myself, and the individuals named above.

☐ I certify under penalty of Oregon State law that the information I have provided within this application is true and accurate to the best of my knowledge and belief.

Employee signature ____________________ Date ____________________

Submit this completed form to your agency/university payroll office.
Please keep a copy of benefit documents for your records.

Oregon TECH
Human Resources

Employee Leave Sample Scenarios
Pregnancy and Maternity Leave

weeks	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Scenario 1: work up to delivery, natural delivery, no complications, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
PFML																																				
STD (only if enrolled)																																				
Scenario 2: work up to delivery, c-section delivery, no complications, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
PFML																																				
STD (only if enrolled)																																				
Scenario 3: doctor puts employee off work 4 weeks prior to due date, natural delivery, no complications, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
PFML																																				
STD (only if enrolled)																																				
Scenario 4: doctor puts employee off due to complications, newborn is ill after 12 weeks of baby bonding, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
OFLA *"Sick Child Leave"*																																				
PFML																																				
STD (only if enrolled)																																				

FMLA	Family Medical Leave Act: Federal law providing up to 12 weeks of leave during Pregnancy Disability and Baby Bonding
OFLA	Oregon Family Leave Act: State law providing up to 12 weeks of leave for "Pregnancy Disability"
OFLA	Oregon Family Leave Act: State law providing up to 12 weeks of leave for "Baby Bonding"
OFLA	Oregon Family Leave Act: State law providing up to 12 weeks of leave for "Sick Child Leave" (very rare)
PFML	Paid Family Medical Leave: (in Oregon) no waiting period, whole day increments only, max of 14 wks for pregnancy & bonding (unless exhausted)
STD	Short Term Disability: (if enrolled) 7 day waiting period, 13 weeks maximum while "disabled" by pregnancy/birth