



**Lane Community College
Medical/Dental/Vision
Insurance Enrollment Application
and Change Form**



SECTION 1: Employee Information

Effective Date of Enrollment/Change: _____ Social Security # : _____

Name: _____ Date of Birth: _____ Hire Date: _____

Address: _____
Street or PO Box City State Zip

Male Female Home Phone: _____ Work Phone: _____

Classification (check one):

- Classified
- Contracted Faculty
- Part-time Faculty
- Management

Coverage Status (check one):

- Active
- Retiree
- COBRA

Marital Status (check one):

- Single
- Married
- Domestic Partner
- Divorced

Enrollment purpose (check one):

- Enrolling employee only at initial eligibility
- Change of dependent(s) coverage at open enrollment
- Adding dependent(s) due to:
 - Marriage (date) _____
 - Birth (date) _____
 - Other (date) _____
- Enrolling employee & dependent(s) at initial eligibility
- Change of address and/or phone number
- Removing dependent(s) due to:
 - Divorce (date) _____
 - Loss of dependent eligibility
 - Other (date) _____
- Name Change - Previous Name: _____

SECTION 2: Dependent Information

Complete for each family member you wish to enroll

Add	Drop	Dependent(s) Full Name	Social Security Number	Date of Birth	Gender	Relationship to Employee

SECTION 3: Other Coverage

Do you or any family members have any other health, dental, vision and/or prescription coverage? No Yes

If yes, please complete the following:

List all insured with other coverage	Other insurance carrier name	Insurance carrier phone number	Policy or ID number	Type(s) of coverage
				<input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Dental <input type="checkbox"/> Vision
				<input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Medicare Information: _____ Part A Part B _____
Name of Insured Original Effective Date

SECTION 4: Child Custody Information

If you are enrolling children of a previous marriage, you must complete this section. Oregon law requires PacificSource and OEA Choice Trust to provide plan information to the custodial parent.

Child's Name	Whose Child	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone Number	If Court Order, Person Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				

SECTION 5: Life Insurance Beneficiary (contracted faculty only)

Life and long term disability (mandatory) Supplemental life insurance (optional, additional form required)

Designate percentage for each beneficiary. Total must equal 100%. This signed form supersedes any previously signed Enrollment Application form.

Name of Beneficiary (please print)	Relationship	Percentage

SECTION 6: Acknowledgement and Declaration

I hereby authorize any medical care institution or medical provider to give my insurance carriers any information related to the physical or mental condition, medical history, or medical treatment of me or my family members requested in the underwriting of my application or in administering claims under my plan(s). Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This authorization will remain valid so long as I remain eligible for benefits.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner;
- A clinic, hospital, long term care, or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- An insurance carrier or group health plan

Furthermore, I authorize that my contributions to the plan be made by Lane Community College on my behalf under the terms of the plan and that my taxable compensation be reduced accordingly. I understand that this contribution amount may not be changed until the next open enrollment period unless I experience a change in status subject to the terms and conditions of the Lane Community College Premium Conversion Plan document. A change in status is defined by birth, adoption, marriage or divorce.

To the best of my knowledge, the information provided on this form is complete and true, and I understand that falsification by me will allow my insurance carriers to recover payment made, cancel my membership and/or refuse to pay claims.

I agree to the terms of this application.

Employee Signature

Date