|  |
| --- |
| ***EMPLOYEE INFORMATION*** |
| Employee Type | Coverage Status | Marital Status | Race |
| [ ] Classified[ ] Management | [ ] Active[ ] COBRA[ ] Retiree | [ ] Single[ ] Married[ ] Domestic Partner | [ ] Asian[ ] Hispanic/Latino[ ] White/Caucasian | [ ] Black/African American [ ] American Indian/Alaska Native[ ] Native Hawaiian/Pacific Islander  |
| L# | Social Security Number | Last Name | First Name | Birth Date | Gender |
|       |       |       |       |       |       |
| Address | City | State | Zip |
|       |       |    |       |
| Home/Cell Phone | Work Phone | Preferred Email Address |
|       |       |       |
| Tobacco Use | Medicare Eligible | Medical Primary Care Provider Name & Address |
| [ ] No[ ] Yes | [ ] No[ ] Yes |            |
|  |  | (for SmartChoice enrollment only) |
|  |
| ***ENROLLMENT INFORMATION*** |
| Medical/Vision/Pharmacy Plan Election (select one) | Dental Plan Election (select one) | Other Coverage |
| PSN Network:[ ]  $800 Deductible | SmartChoice Network:[ ]  $800 Deductible[ ]  $1200 Deductible[ ]  $1800 Deductible | Carrier:[ ]  Moda[ ]  Willamette Dental | Does anyone on your plan have other health insurance coverage?[ ] No[ ] Yes\* |
| \*attach copy of insurance card |
| ***DEPENDENT INFORMATION*** |
| **(attach additional pages if necessary)** You must report to a College benefits administrator within 31 days after a person enrolled as your spouse, domestic partner or dependent child becomes ineligible for benefits. If you make this report on time, the change will be effective the first of the month after your report or the first day of the month after the qualifying event occurred. If you do not report this change in time, LCC may consider that an intentional misrepresentation of a material fact, for which LCC may terminate the family member’s coverage effective the first of the month after eligibility was lost. Attach additional sheets if necessary. **Affidavit Information** – If you are enrolling a domestic partner, an Affidavit of Domestic Partnership must be submitted within five business days of this enrollment, or the individual’s coverage will not be effective. |
| Spouse/Domestic Partner |
| Coverage Status | Relationship | Tobacco Use | Race |
| [ ] Enroll[ ] Remove | [ ] Spouse[ ] Domestic Partner | [ ] No[ ] Yes | [ ] Asian[ ] Hispanic/Latino[ ] White/Caucasian | [ ] Black/African American [ ] American Indian/Alaska Native[ ] Native Hawaiian/Pacific Islander  |
| Social Security Number | Last Name | First Name | Birth Date | Gender |
|       |       |       |       |       |
| Address (if different than member) | City | State | Zip |
|       |       |    |       |
| Medical Primary Care Provider Name & Address (for SmartChoice enrollment only) |
|            |

|  |
| --- |
| Dependent Child |
| Coverage Status | Child of | Tobacco Use | Race |
| [ ] Enroll[ ] Remove | [ ] Mine/Spouse[ ] Domestic Partner | [ ] No[ ] Yes | [ ] Asian[ ] Hispanic/Latino[ ] White/Caucasian | [ ] Black/African American [ ] American Indian/Alaska Native[ ] Native Hawaiian/Pacific Islander  |
| Social Security Number | Last Name | First Name | Birth Date | Gender |
|       |       |       |       |       |
| Address (if different than member) | City | State | Zip |
|       |       |    |       |
| Medical Primary Care Provider Name & Address (for SmartChoice enrollment only) |
|            |
|  |
| Dependent Child |
| Coverage Status | Child of | Tobacco Use | Race |
| [ ] Enroll[ ] Remove | [ ] Mine/Spouse[ ] Domestic Partner | [ ] No[ ] Yes | [ ] Asian[ ] Hispanic/Latino[ ] White/Caucasian | [ ] Black/African American [ ] American Indian/Alaska Native[ ] Native Hawaiian/Pacific Islander  |
| Social Security Number | Last Name | First Name | Birth Date | Gender |
|       |       |       |       |       |
| Address (if different than member) | City | State | Zip |
|       |       |    |       |
| Medical Primary Care Provider Name & Address (for SmartChoice enrollment only) |
|            |

***EMPLOYEE ACKNOWLEDGEMENT, AUTHORIZATION, AND SIGNATURE***

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating healthcare treatment, payment, or for business operations necessary to administer healthcare benefits; or as required by law. 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.

Health or dental 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 acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for this information.*

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, establishment or termination of a domestic partnership, or divorce. Furthermore, I understand that checking “yes” to any of the benefits listed above authorizes Lane Community College to deduct premiums via payroll deduction(s), as applicable.

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 Signed