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

SECTION 1: Employee Information

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

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

Address: _____
Street or PO Box City State Zip

☐Male ☐Female Home Phone: _____ Work Phone: _____

Marital Status (check one): ☐ Single ☐ Married/Domestic Partner
Classification (check one): ☐ Contracted Faculty ☐ Part-time Faculty
Coverage Status (check one): ☐ Active ☐ Retiree ☐ COBRA

Enrollment purpose (check one):
☐ Enrolling at initial eligibility ☐ Open Enrollment ☐ Qualifying Event

SECTION 2: Benefit Plan Selection

☐ **I elect to waive the medical, pharmacy, dental and vision coverage offered by Lane Community College through Oregon Educators Benefit Board.** (Proceed to Section 4)

Medical with Pharmacy (check one):
☐ ODS Medical Plan 3 with Pharmacy Plan B
☐ ODS Medical Plan 5 with Pharmacy Plan B
☐ ODS Medical Plan 8 with Pharmacy Plan B
☐ Providence Medical Plan 2 with Pharmacy Plan 1

Dental with Orthodontia (check one):
☐ ODS Dental Plan 1
☐ ODS Dental Plan 5
☐ Willamette Dental Plan 7

Vision (check one):
☐ ODS Vision Plan 4

SECTION 3: Dependent Information

Complete for each family member you wish to enroll (do not list yourself)

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

SECTION 4: Voluntary Long Term Care

NOTE: All employee coverage elections above the guarantee issue amount and/or beyond the guarantee issue period must be medically underwritten. Additionally, all spouse/partner coverage must be medically underwritten. Please contact Human Resources to obtain the application for this process.

☐ Employee Coverage:
Monthly Coverage (in $1000 increments): $_____
Duration (circle one): 3-Years 6-Years Lifetime
Simple Inflation (circle one): with without
Total Home Care (circle one): with without

☐ Spouse/Partner Coverage:
Monthly Coverage (in $1000 increments): $_____
Duration (circle one): 3-Years 6-Years Lifetime
Simple Inflation (circle one): with without
Total Home Care (circle one): with without

SECTION 5: Voluntary Life

NOTE: Please mark the box for all coverage(s) you are applying for. By selecting "no", an application for coverage at a later date may require further medical information and/or physical exam, which may be at the member's own expense.

Type of Coverage		Amount of Coverage	Premium
Voluntary Employee Life Only Voluntary Employee Life + AD&D *(Up to $200,000 guarantee issue)* *($10,000 increments, maximum $500,000)*	☐ Yes ☐ No ☐ Yes ☐ No **Employees must elect coverage in order to elect spouse and/or dependent coverage**	☐ $10,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ Other: $ _____	
Voluntary Spouse Life Only Voluntary Spouse Life + AD&D *(Up to $30,000 guarantee issue)* *($10,000 increments, maximum $500,000)*	☐ Yes ☐ No ☐ Yes ☐ No **Total requested amount must be equal or less than employee optional life insurance coverage**	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ Other: $ _____	
Voluntary Dependent Child Life Only Voluntary Dependent Child Life + AD&D *($2,000 increments, maximum $10,000)*	☐ Yes ☐ No ☐ Yes ☐ No	☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000	

SECTION 6: Beneficiary Information

The College provides a $100,000 Basic Life insurance policy and a $50,000 Accidental Death & Dismemberment (AD&D) at no cost to the employee. **NOTE:** A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. Attach additional sheets if necessary.

Name	Address	Relationship	Primary Contingent	Percentage
			☐ or ☐	%
			☐ or ☐	%
			☐ or ☐	%
			☐ or ☐	%

SECTION 7: 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. 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 is status is defined by birth, adoption, marriage 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