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

Employee Information

Name:_____ Date of Birth: _____ L #:_____

Address: _____
Street or PO Box City State Zip

Social Security No: _____ Telephone No: _____ ☐Male ☐Female

Classification: ☐Classified ☐Management
Coverage Status: ☐Active ☐Retiree ☐COBRA
Marital Status: ☐Single ☐Married ☐Domestic Partner
Enrollment: ☐New Hire (date of hire) _____ ☐Open Enrollment
☐Marriage (date) _____ ☐ Divorce/Separation (date) _____
☐Birth/Adoption (date) _____ ☐Dependent Status Change (date) _____

Enrollment Information

Medical Plan: ☒PacificSource
Dental Plan: ☐ODS ☐Willamette Dental

Dependent Information

Complete for each family member you wish to enroll

	Name	Social Security No.	Date of Birth	Gender	Relationship
☐Add ☐Remove					
☐Add ☐Remove					
☐Add ☐Remove					
☐Add ☐Remove					
☐Add ☐Remove					

Other Current & Prior Coverage

Do you or any family members have any other health, dental, vision and/or prescription coverage? ☐No ☐Yes
If yes, insurance carrier (check all that apply): ☐Medicare Part A ☐Medicare Part B ☐Other Carrier:_____

Did you or any family members have prior health, dental, vision and/or prescription coverage? ☐No ☐Yes
If yes, type(s) of coverage (check all that apply): ☐Medical ☐Prescription ☐Dental ☐Vision

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.

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

Human Resources Use Only

Effective Date: _____ PS Ref. No. _____ ODS ID No. _____