Lane Community College

Management Retiree Insurance Enrollment Form

For Human Resources Use Only	
Effective Date	
PS Entry Date	
Moda Ref No	

1. Employee Information

Social Security Number:	L#:

Last Name	First Name	MI	Date of Birth

Address ☐ Check if New Address	City	State	Zip

Home Phone	Work Phone	Preferred Email Address

Marital Status	Classification	Coverage Status	*Race/ Ethnicity	Gender	Medicare Eligible
☐ Single ☐ Married/Domestic Partner	☐ Management ☐ Classified	☐ Active Employee ☐ Retiree ☐ COBRA		☐ M ☐ F	☐ Yes ☐ No

*__Race/Ethnicity__: choose one code each family member would most closely identify with: **AIAN**: American Indian/Alaska Native, **A** – Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N** – Native Hawaiian/Other Pacific Islander, **W** – White/Caucasian

2. Enrollment Information

Date of Qualifying Event:	Qualifying Event (mark applicable box below)

☐ New Hire	☐ Open Enrollment	☐ Marriage	☐ Divorce/Legal Separation	☐ Birth/Adoption
☐ Domestic Registration or Affidavit	☐ Involuntary loss of other group coverage	☐ Death of employee	☐ Termination of employment or reduced hours	☐ Dependent no longer meets eligibility

Medical/Vision/Pharmacy Coverage	Dental Coverage
☐ PacificSource Plan A ☐ PacificSource Plan C ☐ PacificSource Plan B	☐ Moda Dental (formerly ODS) ☐ Willamette Dental

3. Dependent Information

You must report to a College benefits administrator within 60 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.

*__Race/Ethnicity__: choose one code each family member would most closely identify with: **AIAN**: American Indian/Alaska Native, **A** – Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N** – Native Hawaiian/Other Pacific Islander, **W** – White/Caucasian

Dependent A ☐ Add ☐ Drop | Medicare Eligible ☐ Yes ☐ No | * Race/Ethnicity:

Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender
						☐ M ☐ F

Dependent B ☐ Add ☐ Drop | Medicare Eligible ☐ Yes ☐ No | * Race/Ethnicity:

Last Name	First Name	MI	Relationship	Social Security No	Birth Date	Gender
						☐ M ☐ F

4. Tobacco Usage

Has anyone on this enrollment form used tobacco an average of 4 or more times a week in the last 6 months. ☐ Yes ☐ No

Name(s)	In a tobacco cessation program? ☐Yes ☐No If yes, list details. Name of program: Date began:	If Native American/Alaska Native, is use for religious or ceremonial purposes? ☐Yes ☐No
Name(s)	In a tobacco cessation program? ☐Yes ☐No If yes, list details. Name of program: Date began:	If Native American/Alaska Native, is use for religious or ceremonial purposes? ☐Yes ☐No

5. Other Coverage

Do you or any person listed on this application have or have had health insurance in the last 24 month? If yes, complete the following **and** attach proof with dates of coverage. ☐ Yes ☐ No

Name(s)	Insurance Carrier	Date(s) of Coverage	Will Coverage Continue?	Plan Type
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Dental
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Dental

6. Life Insurance Beneficiary Information

For those eligible management retirees, a $50,000 life insurance policy is included. 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 ☐	%

7. 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 is 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