

LANE COMMUNITY COLLEGE – SECTION 125 EMPLOYEE ENROLLMENT FORM (2017)

SUBMIT FORMS TO: 4000 E 30th Ave., Eugene, OR 97405 OR Fax (541) 463-3970 | Plan Administered by Polestar Benefits, Inc.

EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	SSN	DATE OF BIRTH	L#
MAILING ADDRESS			CITY	STATE	ZIP
EMAIL ADDRESS			PHONE	☐ CONTRACTED FACULTY ☐ PART-TIME FACULTY	☐ MALE ☐ FEMALE ☐ CLASSIFIED ☐ MANAGEMENT

DEPENDENT INFORMATION (attach additional pages if needed)

Would you like an additional benefits card for your spouse?			☐ YES	☐ NO
SPOUSE NAME		DATE OF BIRTH	SSN (REQUIRED)	
CHILD NAME		DATE OF BIRTH	SSN (REQUIRED)	
CHILD NAME		DATE OF BIRTH	SSN (REQUIRED)	
CHILD NAME		DATE OF BIRTH	SSN (REQUIRED)	

PLAN ELECTION(S)

List EMPLOYEE contribution only. Do not include any employer contribution in the election amount(s) below.

FLEXIBLE SPENDING ACCOUNT ELECTION (medical, dental and vision related expenses for you and eligible dependents)			DEPENDENT CARE ACCOUNT ELECTION (daycare related expenses for eligible dependents)		
PER PAY PERIOD DEDUCTION	# OF PAY PERIODS	ANNUAL ELECTION	PER PAY PERIOD DEDUCTION	# OF PAY PERIODS	ANNUAL ELECTION
\$		\$	\$		\$

DIRECT DEPOSIT (optional)

By electing to have my reimbursements directly deposited, I understand that: 1. Direct deposits are intended to be a more efficient way of receiving reimbursement. Direct deposit is not always a quicker way of receiving reimbursement; 2. Once Polestar Benefits, Inc. receives a completed and signed Authorized on Agreement; it will take approximately 7 – 10 business days to set-up and activate a direct deposit; 3. The date a claim is processed is not always the date the funds are deposited in my account. By providing the bank information below, I acknowledge that I have read and understand these statements. I hereby authorize Polestar Benefits, Inc. to initiate direct deposits to this bank account. It is my responsibility to notify Polestar Benefits, Inc. of any changes relating to my account. I may cancel the direct deposit option at any time.

BANK ACCOUNT INFORMATION	☐ CHECKING ☐ SAVINGS	ACCOUNT #	ROUTING #
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ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Polestar Benefits, Inc. plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to change or revoke this authorization by written notice if there is one or more significant change in status (i.e. marriage, death, divorce, separation, birth, etc). I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete. *****125/FSA Acknowledgement***** The dependents for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for support. I am aware the premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded. Reimbursement account claims must be accompanied by proper documentation (i.e. a reimbursement request and related receipt(s) or Explanation of Benefits) of the out-of-pocket expense and be incurred within the plan year. This agreement cannot be revoked or changed, unless I experience a qualified change in status. **WARNING:** Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud, which is a crime.

Employee Signature				Date Signed
FOR HUMAN RESOURCES USE ONLY				
Effective Date	First Payroll Date	Employer Contribution	Massage Benefit Eligible	Pay Date Ranges (for less than 24)
01/01/2017	01/10/2017	\$	☐ Yes ☐ No	