Lane Community College
HUMAN RESOURCES

HEALTH CLINIC DEPENDENT COVERAGE
Enrollment and Change Form

Name _____ L# _____

Lane Community College Health Clinic service is available to dependent(s) of classified employees. This is a voluntary benefit and is paid by the employee through post-tax, semi-monthly payroll deduction at the cost of $4.00 per month per dependent. Dependent(s) must meet both of the following criteria in order to be eligible for services at the Health Clinic:

1. Dependent(s) must currently be enrolled on the employee's health insurance plan through Lane Community College.
2. Dependent(s) must be sixteen (16) years of age or older.

Dependent Information

Please enroll my dependent(s) listed below in the voluntary Health Clinic benefit:

Dependent Name	L Number*	Date of Birth	Relationship to Employee

Total Number of Dependent(s) Listed Above: _____ x $4.00 per month = $ _____ cost per month

*Please provide your dependent's social security number if s/he does not have, or does not know, the L number.

Acknowledgement and Declaration

To the best of my knowledge, the information provided on this form is complete and true, and I understand that falsification by me will cancel this election and future service will be denied. Furthermore, I understand that this election cannot be changed until the next open enrollment period unless I experience a change in family status, as defined by birth, adoption, marriage, or divorce.

By signing below, I agree to the terms of this enrollment and I hereby authorize Lane Community College to deduct the premium from my paycheck.

Employee Signature _____ Date _____

Please return this form to LCC Human Resources.
If you have any questions, please contact a Benefits Analyst at ext. 5586.

Human Resources Use Only

Coverage Effective Date _____ Qualifying Event _____

Banner Effective Date _____ Dependent Status Verified by _____