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
Ethnicity (check one): ☐Hispanic ☐Non-Hispanic/Non-Latino ☐Refused ☐Unknown
Race (may check multiple): ☐Asian ☐Black/African American ☐American Indian/Alaska Native ☐White
☐Native Hawaiian/Other Pacific Islander ☐Other ☐Refused ☐Unknown

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 7 with Pharmacy Plan B
☐ODS Medical Plan 8 with Pharmacy Plan B

Dental with Orthodontia (check one):
☐ODS Dental Plan 1
☐ODS Dental Plan 4
☐Willamette Dental Plan 8

Vision (check one):
☐ODS Vision Plan 4

SECTION 3: Dependent Information

Complete for each family member you wish to enroll

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

SECTION 4: 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