Lane Community College

Classified Employee Insurance Change Form

For Human Resources Use Only	
Effective Date	11/01/2016 open enrollment
PS Entry Date	
MODA Ref No	

1. Employee Information

Social Security Number:	L#:	Date of Birth	Gender ☐ M ☐ F	Medicare Eligible ☐ Yes ☐ No
Last Name	First Name			MI
Address ☐ Check if New Address	City		State	Zip
Home Phone	Work Phone	Preferred Email Address		

Marital Status
☐ Single
☐ Married
☐ Domestic Partner

Coverage Status
☐ Active Employee
☐ Retiree
☐ COBRA

*Race
☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ White/Caucasian

Medical Primary Care Provider Name and Address (for SmartChoice enrollment only) — Current Patient? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

2. Enrollment Information

Medical/Vision/Pharmacy Plan Election (select one)		Dental Plan Election (select one)
PSN Network:	SmartChoice Network:	Carrier:
☐ $500 Deductible	☐ $500 Deductible	☐ MODA
☐ $750 Deductible	☐ $750 Deductible	☐ Willamette Dental
☐ $1000 Deductible	☐ $1000 Deductible	

3. Dependent Information **(attached additional pages if necessary)**

You must report to a College benefits administrator within 31 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.

Spouse/Domestic Partner ☐ Enroll ☐ Remove ☐ Male ☐ Female Medicare Eligible ☐ Yes ☐ No

Last Name	First Name	MI	Social Security No	Birth Date

Address (if different from Member)

Race
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian

Medical Primary Care Provider Name and Address (for SmartChoice enrollment only) — Current Patient? ☐ Yes ☐ No

Does dependent use tobacco? ☐ Yes ☐ No

Is dependent enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child ☐ Enroll ☐ Remove ☐ Male ☐ Female Medicare Eligible ☐ Yes ☐ No

Last Name	First Name	MI	Social Security No	Birth Date	Child of ☐ Mine ☐ Partner

Address (if different from Member)

Race
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian

Medical Primary Care Provider Name and Address (for SmartChoice enrollment only)	Current Patient? ☐ Yes ☐ No

Does dependent use tobacco? ☐ Yes ☐ No	Is dependent enrolled in a tobacco cessation program? ☐ Yes ☐ No	Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child ☐ Enroll ☐ Remove ☐ Male ☐ Female Medicare Eligible ☐ Yes ☐ No

Last Name	First Name	MI	Social Security No	Birth Date	Child of ☐ Mine ☐ Partner

Address (if different from Member)

Race
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian

Medical Primary Care Provider Name and Address (for SmartChoice enrollment only)	Current Patient? ☐ Yes ☐ No

Does dependent use tobacco? ☐ Yes ☐ No	Is dependent enrolled in a tobacco cessation program? ☐ Yes ☐ No	Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

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 Signed