Open Enrollment Form 2013-14 Lewis & Clark College

Important: The Information On This Form Will Replace Any Previous Enrollment Information Submitted By You!							
1. PERSONAL INFORMATION							
Employee Name (Last, First, Middle Initial)				Daytime Phone	Sex	x	
Mailing Add	Mailing Address (Number, Street, City, State, ZIP) Date of Hire						
SSN/Employee ID				Date of Birth	Ма	rital Status	
2. TYPE OF ACTION							
☐ Enroll in a ☐ Medical ☐ Dental Plan (complete sections 3 and 4)							
☐ Change my ☐ Medical ☐ Dental plan (complete sections 3 and 4)							
☐ Cancel my ☐ Medical ☐ Dental Plan (complete section 3)							
Add dependent(s) to Medical Dental (check appropriate box(s) and complete section 4)							
☐ Delete dependent(s) from my ☐ Medical ☐ Dental (check appropriate box(s) and dependent information directly below)							
Dependent's Name (Last, First, Middle Initial) Dependent's Name (Last, First, Middle Initial)							
Is this due to Legal Separation or Divorce? Yes NoIf yes, provide ex-spouse's name							
3. ENROLLMENT INFORMATION							
Medical/Vision/Prescription Plan Desired							
Pioneer Medical - administered by Regence BlueCross/BlueShield (PPO) Kaiser Permanente - Medical (HMO)							
☐ I wish to decline medical coverage for myself and my dependents due to other coverage.							
Dental Plan Desired							
Pioneer Dental - administered by Regence BlueCross/BlueShield (FFS)							
☐ Willamette Dental Plan (HMO)							
☐ Kaiser Dental Plan (HMO)							
☐ I wish to decline dental coverage for myself and my dependents due to other coverage.							
Pre-Tax Premiums							
Your Medical/Dental Premiums will automatically be deducted from your pay on a pre-tax basis. This will increase your take							
home pay. If you wish to waive this option and pay your premiums post-tax, check here:							
4. ELIGIBLE FAMILY MEMBERS							
If you are changing or enrolling in your medical or dental plan, list all eligible family members covered under the plan(s). Attack separate short if possessing.							
plan(s). Attach separate sheet if necessary. If you are adding a new dependent(s), check box to the left and include information about the new dependent(s) only.							
Med, Vis, & Rx	Den	Relationship	Name: (Last, First, MI)	Social Security Number	Sex M/F	Date of Birth	
*Please Note: A signed affidavit of Marriage/Domestic Partnership is required to enroll a spouse/domestic partner.							
		Spouse/ Domestic Partner*					
		Dependent					
		Dependent					
		Dependent					
Application Agreement							
I authorize my employer to deduct from my salary or wages, if applicable, the necessary premiums for the coverage requested. My signature also verifies the accuracy of the information on this form. Changes in coverage during the plan year may be made with the occurrence of a qualifying event, as defined by the internal revenue code, within 31 days of the event. Requested changes must be consistent with the nature of the qualifying event. This includes additions, cancellations/removal or dependents termination of coverage or any other changes. If you enroll a dependent that is not eligible, you will be responsible to repay any payments made on behalf of the ineligible dependent. If I decline all or a portion of any of the offered benefits, I understand that I will be subject to the restrictions upon subsequent applications and may need to provide satisfactory evidence of insurability. Each of the benefits plans is governed by an official plan document. If any discrepancies arise between any summaries and the official plan documents, the official plan document will be regarded as the final authority.							
Signature Date							