Lewis & Clark College: Benefits Enrollment/Change Form

2013-14

Reason For Completing This Form

IMPORTANT: THE INFORMATION ON THIS FORM WILL REPLACE ANY PREVIOUS ENROLLMENT INFORMATION SUBMITTED BY YOU.

- ☐ New Employee
- ☐ Change in Employment Status
- ☐ Beneficiary Change
- ☐ Marriage/Domestic Partnership
- ☐ Birth/Adoption
- ☐ Death
- ☐ Loss of Other Insurance
- ☐ Gained New Insurance
- ☐ Divorce/Dissolution of Domestic Partnership
- ☐ Other:

Employee Name (Last, First, MI)				Sex
Home Address		Apt#	City	
State	Zip	Social Security Number/Employee ID	Date of Birth	Marital Status
Home Phone	Work Phone	Hire Date	Email	

Medical/Vision/Prescription Plan Desired

- ☐ PPO Medical Plan: Pioneer Educators Health Trust (administered by *Regence* BlueCross/BlueShield)
- ☐ HMO Medical Plan: Kaiser Permanente

Dental Plan Desired

- ☐ FFS Dental Plan: Pioneer Educators Health Trust (administered by *Regence* BlueCross/BlueShield)
- ☐ Willamette Dental Plan
- ☐ Kaiser Dental Plan

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: ☐

Benefits Enrollment for Your Family

Med, Vis, & Rx	Den	Relationship	Name: (Last, First, MI)	Social Security Number	Sex M/F	Date of Birth
☐	☐	Spouse/ Domestic Partner* (my signed affidavit is attached w/ this form)				
☐	☐	Dependent				
☐	☐	Dependent				
☐	☐	Dependent				
☐	☐	Dependent				

Please Note: An eligible dependent includes spouse/domestic partner (*signed affidavit of Marriage/Domestic Partnership required to enroll) and dependent unmarried children up to age 26. If you enroll a dependent that is not eligible, you will be responsible to repay any payments made on behalf of the ineligible dependent.

Other Insurance Coverage - For Coordination of Benefits

Do you or any of the above covered dependents have ANY other health care coverage that will continue after your enrollment date?
☐ No ☐ Yes (If yes, you MUST complete the following)

Insurance Name	Effective Date
Policy Holder's Name	Policy #
Person's Covered	Date Coverage Ends

Please Turn Over

Refusal Of Insurance – Due to Other Coverage

I understand that if I refuse coverage, my ability to obtain benefits under health plans may be restricted by the guidelines set forth by each carrier. Employees who provide proof of medical coverage elsewhere and who choose to waive coverage will receive $25.00 per month for use to purchase other benefits or receive as additional taxable income.

I decline the following coverage(s) for MYSELF:	☐ Med, Vis, & Rx	☐ Dental	Due to other coverage: ☐ Yes ☐ No
I decline the following coverage(s) for my DEPENDENTS:	☐ Med, Vis, & Rx	☐ Dental	Due to other coverage: ☐ Yes ☐ No

Dependents declining: ☐ Spouse/Domestic Partner Only ☐ Spouse/Domestic Partner & Child (ren) ☐ Child (ren) Only

Beneficiary Information: For Your College & Employee Paid Life and AD&D Insurance (FTE =.75 – 1.0)

Beneficiary (Last, First, MI)	SS#	Date of Birth	Relationship

Beneficiary Address	City	State	Zip

Please note: Be sure to name a beneficiary for your life insurance. If you are divorced, the spouse you named as the beneficiary will automatically be eliminated as the beneficiary, unless you complete a new enrollment form after the divorce and designate your former spouse as the beneficiary. The beneficiary listed above applies to both your College & Employee paid Life Insurance policies. If you would like to name separate beneficiaries for the College paid and the Employee paid policies you may do so on a separate piece of paper.

Flexible Spending Accounts – New Hire, Open Enrollment, & Qualifying Event Only! (Plan Year: April 1 – March 31)

I authorize the "before-tax" deduction of a portion of my pay. I am aware that "before-tax" elections are exempt from Federal, State, FICA, and Medicare taxes. My health FSA election is for medical, dental, and vision expenses for myself, my spouse and my qualifying dependents. My dependent care FSA election is for the care of my tax dependent children, under age 13, or individuals unable to care for themselves, residing with me at least 8 hours each day. I am aware that my unused contributions made to the health FSA and the dependent care FSA cannot be refunded to me. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense. I understand that coverage applies only to expenses incurred within the plan year (April 1 – March 31), starting on the effective date of my benefits, and during my period of employment. I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

☐ Health Flexible Spending Account (Plan year Maximum - $2,500)	**Per Pay-period**	**# of Pay-periods left in plan year (April 1 - March 31)**	**Annual Election (Per pay period x # of pay periods left) =**
☐ Dependent Flexible Spending Account (Plan year Maximums - $5,000 – Head of household or married filing jointly or $2,500 if married filing separately)	**Per Pay-period**	**# of Pay-periods left in plan year (April 1 - March 31)**	**Annual Election (Per pay period x # of pay periods left) =**

Flex Debit Card

BY ELECTING THE FLEX DEBIT CARD: I may only use the card to pay for eligible medical expenses. I may not use the card for expenses already reimbursed. I may not seek reimbursement under any other health plan for expenses paid with the card. I will acquire and provide documentation for expenses paid with the card.

☐ Yes, I would like the flex debit card for the current plan year.
☐ Yes, I would like a card for my spouse.

Application Agreement

I authorize Lewis & Clark College to deduct from my salary or wages, if applicable, the necessary premiums for the coverage requested. Insurance premiums are paid one month in advance. If the deadline for the payroll deductions has passed, we will arrange a payroll deduction of 1.5x the benefit premiums for two pay periods to cover the cost of the first month's premium payment. Processing the adjustment pre-tax through payroll will save you money on taxes, but if you prefer, we will also accept a check or money order. 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 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.

I hereby verify that all the information provided on this form is accurate and complete. I have also read and understood the Application Agreement.

Signature **Date**

Return this completed form to Human Resources, Campus Box 72
Your application is not complete until the printed and signed version has been received by the Human Resources Office.