Lewis & Clark College: Benefits Enrollment/Change Form

2009 - 2010

Print Form

Reason For Completing This Form

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

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

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

Medical/Vision/Prescription Plan Desired

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

☐ HMO Medical Plan: Kaiser Permanente	% of time in NW Service Area? _____%	Previously Covered by Kaiser? ☐ Yes ☐ No	Previous Name & Health Record #:

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: ☐

Enrollment for Dependents

Med, Vis, & Rx	Den	Relationship	Name: (Last, First, MI)	Social Security Number	Sex M/F	Date of Birth
☐	☐	Spouse/ Domestic Partner*				
☐	☐	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 23. 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

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.

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 College & Employee Paid Life and AD&D Insurance

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.

Personal Choice Flexible Spending Accounts New Hire, Open Enrollment, & Qualifying Event Only!

	Per Pay-period	# of Pay-periods	Annual Election
☐ Health Care Spending Account (Plan year Maximum - $6,000)			
☐ Dependent Care Spending Account (Plan year Maximums - $5,000 – Head of household or married filing jointly or $2,500 if married filing separately)			

In consideration of my employer allowing me to participate in its flexible spending accounts, I acknowledge and agree as follows:
I agree to abide by the terms, conditions, and provisions of the FSA contained in the Plan Document, I acknowledge my right to examine the Plan Document or obtain a copy of it by giving reasonable advance notice to the Human Resource department. I acknowledge the IRS permits me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my elections and I assume full responsibility for all taxes, penalties, interest, or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements for disallowed expenses.

I understand that the IRS prohibits me from claiming the federal child care tax credit for dependent care assistance expenses which are reimbursed to me. I choose to participate despite my knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) and that this may reduce my Social Security benefits upon retirement. I understand that I must claim reimbursement for eligible expenses incurred during the plan year on or before 90 days after the last day of the plan year or I will forfeit those reimbursements. I further acknowledge that I will forfeit all funds credited to my FSA accounts which are not reimbursed to me. Please note that reimbursements must be received by the last day of the run-out, not postmarked. I have been informed that my participation in my FSA will have tax and economic consequences to me and that before deciding to participate, I may wish to seek professional advice regarding the benefits, risks, and limitations.

Application Agreement & Release Of Information

- ✓ 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 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.

Health Information requested or disclosed may be related to treatment or services performed by:
- ✓ A physician, dentist, pharmacist, or other physical or behavioral health care practitioners;
- ✓ 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 information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostics 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 hereby verify that all the information specified above is accurate and complete. I have also read and understood the Application Agreement and Release of Information.*

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.