

# Lewis & Clark College Medical/Dental Enrollment Form

Name ( Last, First M.I.): \_\_\_\_\_ Sex: M / F  
 Home Address: \_\_\_\_\_ Apt. No: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**MEDICAL/VISION/PRESCRIPTION:**

- Pioneer POS:** Participating Networks (**You must choose one**) –  
 Managed Healthcare Northwest (MHN)     Providence Preferred PPO
- Kaiser Permanente HMO Plan** (Group & Subgroup number 1495-001)

**If you elected Kaiser Permanente:** What percentage of time do you work in the Kaiser Permanente Northwest service area? \_\_\_\_\_ %

Have you or your dependents previously had Kaiser Permanente coverage in this region?  Yes     No  
 If yes: Name: \_\_\_\_\_ Former name, if different: \_\_\_\_\_

**Administrator Use Only**

Hire Date: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_  
 Date of Qualifying Event: \_\_\_\_\_

**New Employee**       **Open Enrollment**  
 **Add dependent:**  birth;  marriage;  
 adoption;  loss of coverage;  
 legal guardianship;  other  
 **Cancel dependent:**  divorce;  over 23;  
 other coverage;  death  
 **Employee Termination**  
 **Name /Address change**  
 **Other**  
 **Transfer to COBRA:**  Over age;  
 Termination;  Divorce;  Death;  
 Reduction in Hrs.;  Disability

**Administrator's  
Signature:** \_\_\_\_\_

Health Record number: \_\_\_\_\_

**DENTAL COVERAGE:**     **FFS DENTAL** or     **Willamette DENTAL**

Med./Vis.	Den.	Name: (Last, First Middle Initial)	Relationship	Social Security Number	Sex	Date of Birth
			Self			
			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Prtn.			
			Child			
			Child			
			Child			
			Child			
			Child			

**Do you or any of your dependents applying for coverage have coverage now through ANY health care plan?**     Yes     No

**If you or your dependents have coverage through any health care plan, you MUST complete the following:**

Other Insurance:    Company Name: \_\_\_\_\_    Policy #: \_\_\_\_\_  
 Policy Holder's Name: \_\_\_\_\_    Person's Covered: \_\_\_\_\_  
 Date Coverage Began: \_\_\_\_\_    Date Coverage Ends: \_\_\_\_\_  
 Person's Covered: \_\_\_\_\_

(OVER)

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**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:  Medical/Vision/Prescription  Dental I am declining due to other coverage:  Yes  No  
I decline the following coverage(s) for my dependents:  Medical/Vision/Prescription  Dental I am declining due to other coverage:  Yes  No  
Dependents declining:  Spouse Only  Spouse & Child(ren)  Child(ren) Only

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**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 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.

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**RELEASE OF INFORMATION:**

**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.**

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*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.*

**X Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*After completing, please print and sign this form and return it to the Human Resource Office (MSC 72).  
Your application is not complete until the printed and signed version has been received by the Human Resources Office.*