

ENROLLMENT/CHANGE FORM

COVERAGE INFORMATION:

Name of Employer/Plan Sponsor: Lansing Community College Group Number: 71565		Effective date of enrollment or change:
Plan Choice:	\$500/\$1000 PPO Select \$250/\$500 Versatile \$1000/\$2000 PPO Plan 3 \$1350/\$2700 Flexible Blue \$3000/\$6000 Essential HDHP	Reason for enrollment or change: Initial Enrollment Following Hire Open Enrollment Cancel Coverage Status Change: Other:

EMPLOYEE INFORMATION:

Name (Last, First, MI):		Home Street Address:	
Gender: Female Male		City:	State:
Birth Date (MM/DD/YYYY):	Age:	ZIP Code:	
Social Security Number:		Telephone (home/cell):	
Date of Hire:	Full-time or Part-time Employee:	Full-time	Part-time

DEPENDENT INFORMATION:

Add/Remove /Change	Relationship (to employee)	Name (Last, First, MI)	Birth Date (MM/DD/YYYY)	Gender (F/M)	Social Security Number

EMPLOYEE CERTIFICATION AND SIGNATURE:

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent’s status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings.
- I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a “change in status” or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.

EMPLOYEE SIGNATURE:

DATE: