Sandia National Laboratories

Employee Health Plan Benefits Enrollment/Disenrollment Packet

IMPORTANT ENROLLMENT REQUIREMENTS

STEP 1: Send your completed enrollment form to Benefits. **We MUST receive this form within 31 calendar days of the mid-year election change event.**

STEP 2: Send follow up documentation to Benefits. **This documentation will be required within 60 days of the mid-year election change event.**

Qualifying midyear enrollments of dependents require documentation (e.g., proof of birth/birth certificate, marriage certificate, adoption papers, or loss of previous employer coverage) before the dependent will be enrolled. Failure to provide this documentation will result in disqualification of the dependent for coverage.

Refer to pre-tax premium booklet for qualifying mid-year election change events.

When to Enroll or Disenroll in Health Plans

Mid-Year: If you have a dependent who becomes newly eligible for medical, dental and/or vision coverage through Sandia, you must enroll that dependent within **31** calendar days of the event (e.g., birth, adoption, marriage, etc.) qualifying them for coverage.

If you have a dependent who becomes newly ineligible for medical, dental and/or vision coverage through Sandia, you must disenroll that dependent within **31** calendar days of the event (e.g. divorce, child marries, child is no longer financially dependent, etc.). Plan coverage ends at the end of the month in which he/she became ineligible.

Open Enrollment: If you miss the **31** day period, the next opportunity for you to enroll your eligible dependent will be during Sandia's Open Enrollment period in the fall with coverage effective January 1 of the following year.

You must also provide a birth or marriage certificate, adoption papers, or any other required documentation within **60** calendar days from the end of Open Enrollment period.

Contact HBE at (505) 844-4237 for assistance.

Health Benefits Employee Services

HBE

CHECK ONE:

☐ ENROLLMENT — Complete Sections A, B, E & F

☐ DISENROLLMENT — Complete Sections A, C, E & F

☐ WAIVE — Complete Section A, D & E

MEDICAL PLAN:

☐ UHC Premier PPO ☐ CIGNA Premier PPO ☐ UHC Standard ☐ CIGNA In-Network ☐ Kaiser (CA)

A. Primary Member Information

Last Name		First Name		Middle Initial	
SNL I.D. :		Date of Birth			
Street Address		City, State		Zip Code	
Home Phone		Work Phone			

B. Enrollment Information

☐ **New Enrollment** ☐ **Adding a dependent** ☐ **Return from Leave of Absence**

TYPE OF ENROLLMENT (Check one)

☐	Birth **(Provide proof of birth/birth certificate)**
☐	Marriage **(Provide marriage certificate)**
☐	Legal Guardianship (**Include Official Court Guardianship papers)**
☐	Adoption/Adoption Placement **(Include Official Court Adoption/Placement papers)**
☐	Domestic Partner/Dependent **(Include Dependent Affidavit**)
	SF 4400-DPA Domestic Partner Affidavit Form
☐	Loss of Coverage **(Provide Certificate of Creditable Coverage Form From Previous Employer)**
☐	Other **(Indicate Qualifying Event):**

DATE OF QUALIFYING MID-YEAR ELECTION CHANGE EVENT		**IMPORTANT: You must provide the date of the mid-year election change event** (e.g., marriage, birth, adoption date, etc.)

B. Enrollment Information (continued)

Dependent Information: Please list each family member below that you wish to ENROLL.

See notes top of Page 3 for additional information regarding this section.

Last Name	First Name	M. In.	Relation to Employee	SSN No.	Gender	Birth Date	Medical	Dental	Vision
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

NOTE: If you are currently covered and are adding a new family member(s), you only need to list the new addition(s) to your plan. If you have more than five dependents, please complete an additional enrollment form.

NOTE: No one (employees/retirees or eligible dependents) may be covered as both a primary participant and a dependent or as a Dependent under two different Sandia employees/retirees.

NOTE: A Social Security number for newborns is NOT a requirement to enroll. As soon as you receive the SSN, contact HBES at (505) 844-4237 with the information.

Please refer to the applicable Summary Plan Description for a listing of eligible dependents

DEFINITION OF "CHILD/CHILDREN"

Child (Children) include:

- The primary covered member's or domestic partner's own child(ren) and legally adopted children
- Adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits)
- Stepchildren living with the primary covered member or domestic partner (stepchildren visiting for the summer are not considered to be living with you).
- Child for whom the primary covered member or domestic partner has legal guardianship
- Natural child, legally adopted child, or child for whom the primary covered member or domestic partner has legal guardianship if a court decree requires the primary covered member or domestic partner to provide coverage and the child meets the eligibility requirements.

Other Health Care Coverage:

You are responsible for updating your coordination of benefits information with your respective health insurance carrier (UHC, CIGNA or KAISER). The process is designed to inform the plans whether dependents have other coverage so the right health plan will pay correctly, and until the data is received, the processing of dependent claims could be affected. You can provide this data in one of three ways. For UHC, go to www.myuhc.com and add the information under "Manage My Account," call UHC at (877)-835-9855 or wait until a claim gets held and you receive a letter requesting the information. For CIGNA, go to www.mycigna.com, call CIGNA at (800) 244-6224 or wait for a form the company will send to your home. KAISER (CA only) www.kp.org or customer service (800) 464-4000. This process should be completed on an annual basis.

C. Disenrollment Information

TYPE OF DISENROLLMENT (Check one)

☐	Divorce/Annulment **(Include only first page of final divorce decree or annulment)**
☐	Legal Separation (**Include only first page of final legal separation papers)**
☐	Child marries
☐	Child no longer financially dependent
☐	Child no longer meets the age criteria
☐	Dissolution of Domestic Partnership
☐	Death
☐	Other (Indicate Qualifying Event):

DATE OF QUALIFYING MID-YEAR ELECTION CHANGE EVENT		**IMPORTANT: You must provide the date of the mid-year election change event** (e.g., divorce, legal separation, child marries, etc.)

C. Disenrollment Information (continued)

Dependent Information: Please list each family member below that you wish to DISENROLL

Last Name	First Name	M.I.	Relationship to Employee	SSN No.	Gender	Birth Date	Medical	Dental	Vision
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

Note: If you waive/drop coverage for yourself and your dependents because of other health insurance coverage and you and/or your dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your dependents during the plan year, provided that you request enrollment within 31 calendar days after your other coverage ends. In addition, if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption or placement for adoption.

D. Waiver of MEDICAL Coverage

To waive medical coverage for yourself and your dependents, you must fill out the information requested below.

I, _____ SNL I.D.: _____

Waive coverage for myself and all of my dependents, including Class II's, in any of Sandia's medical plans. I understand the benefit I am waiving and that Sandia is not responsible for any medical expenses incurred by me or my dependents during the period in which these benefits are waived. I also understand that my next opportunity to enroll in a Sandia medical plan will be during the Open Enrollment period for coverage the next calendar year or based on a mid-year election change event (See note above)

Signature:	**Date:**

D. Waiver of DENTAL Coverage

To waive dental coverage for yourself and your dependents, you must fill out the information requested below.

I, _____ SNL I.D.: _____

Waive coverage for myself and all of my dependents in any of Sandia's dental plans. I understand the benefit I am waiving and that Sandia is not responsible for any dental expenses incurred by me or my dependents during the period in which these benefits are waived. I also understand that my next opportunity to enroll in a Sandia dental plan will be during the Open Enrollment period for coverage the next calendar year or based on a mid-year election change event. (See note above).

Signature:	**Date:**

D. Waiver of VISION Coverage

To waive vision coverage for yourself and your dependents, you must fill out the information requested below.

I, _____ SNL I.D.: _____

Waive coverage for myself and all of my dependents in Sandia's vision plan. I understand the benefit I am waiving and that Sandia is not responsible for any vision expenses incurred by me or my dependents during the period in which these benefits are waived. I also understand that my next opportunity to enroll in a Sandia vision plan will be during the Open Enrollment period for coverage the next calendar year or based on a mid-year election change event. (See note above)

Signature:	**Date:**

E. Health Plans Insurance Premium Authorization Form

Your signature below authorizes Sandia to increase or decrease your health care premium amount.

PRIMARY SUBSCRIBER:

SNL I.D.:		Last Name:		First Name:		M. I.:	

MEDICAL PLAN:

☐	UHC Premier PPO	☐	CIGNA Premier PPO	☐	UHC Standard	☐	CIGNA In-Network	☐	Kaiser

TYPE OF ENROLLMENT (Check one):

☐	New	☐	Change	☐	Return From Leave Of Absence	☐	Waiver (Section D)

WHO WILL BE COVERED WITH THIS CHANGE? (Check one):

☐	Employee Only	☐	Employee And Child(ren)	☐	Employee And Spouse	☐	Employee And Spouse Plus Child(ren)

OTHER CHANGE:

☐	Domestic Partner	☐	Domestic Partner And Child(ren)

BENEFITS DEPARTMENT USE	
Effective Date:	
Salary Tier:	
Union:	

Employee Signature: **Date:**

F. Employee's Signature

Authorize Elections

I understand that if a covered individual is injured through the act or omission of another, the Health Plans require reimbursement for the benefits. I agree that the information provided in this packet is true and correct to the best of my knowledge.

IMPORTANT NOTE: Benefits MUST receive this form within 31 calendar days of the mid-year election change event.

Employee Signature	SNL I.D.	Date

Complete this form and Fax to: (505) 844-7535

Alternatively, mail to: Sandia National Laboratories
Attn: Benefits
PO Box 5800 MS-1463
Albuquerque, NM 87185-1463

Contact Information:

For additional Information: Health Insurance and Health, Benefits & Employee Services

Health, Benefits & Employee Services

Phone: (505) 844-4237

Email: mailto:hbe@sandia.gov

FOR BENEFITS USE ONLY	
Date COBRA notice mailed to spouse	Effective Date of Disenrollment Date of COBRA worksheet
Signature of Benefits representative	Date change entered in SNL database