Sandia National Laboratories

SANDIA PROPRIETARY INFORMATION
PERSONALLY IDENTIFIABLE INFORMATION (PII) (WHEN COMPLETE)

Employee Health Plan Benefits Enrollment/Disenrollment Packet

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

IMPORTANT ENROLLMENT REQUIREMENTS	
STEP 1:	**Complete Section A.**
STEP 2:	**Review the eligibility criteria located in Section 3 of the Sandia Health Benefits Plan for Employees Summary Plan Description (SPD) to ensure your dependent meets the eligibility criteria.**
STEP 3:	**Review the enrollment and disenrollment mid-year election table and mark the appropriate change event. The table describes mid-year election supporting documentation requirements (if applicable). This documentation can follow the submission of the enrollment form, but is required within 60 days of the mid-year election change event. Your change will not be entered into the HR system until after Benefits receives the documentation. Failure to provide this documentation will result in disqualification of the dependent's coverage.**
STEP 4:	**Sign Section D to certify the enrollment action request.**
STEP 5:	**Benefits MUST receive this form within 31 calendar days of the mid-year election change event.** **For births, adoptions, or placements for adoptions, you have retroactive coverage to the date of the event if enrolled within 31 calendar days of the event; however, you may enroll these dependents between 31-61 calendar days after the event with coverage effective on the date the paperwork is received by the Benefits Department.**
STEP 6:	**Fax your completed enrollment form to Benefits at 505-844-7535 or mail to MS-1022.**
STEP 7:	**You will receive a confirmation email from Benefits when your enrollment or disenrollment has been processed.**

A. Primary Member Info and Qualifying Election Change Information

First Name		Last Name		M.I.	
SNL I.D.		Org.		Date of Birth	
Street Address		City, State		ZIP Code	
Work Phone		Home Phone			

CHECK (all that apply):

☐ New (Employee currently not enrolled)

☐ ENROLLMENT Complete Sections A, B, & D	☐ DISENROLLMENT (specific family member) Complete Sections A, C, & D	☐ WAIVE (Sandia coverage)* Complete Sections A, C, & D

☐ Employee Only	☐ Employee and Child(ren)	☐ Employee and Spouse	☐ Employee and Spouse plus Child(ren)

HEALTH PLAN (mark all that apply):

☐ Sandia Total Health BCBSNM	☐ Sandia Total Health UHC	☐ Sandia Total Health Kaiser
☐ Dental Plan	☐ Vision Plan	

☐ **CLASS II DEPENDENT CANCELLATION**

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.)
Benefits Department Use Only	**Effective Date:**

B. Qualifying Enrollment Mid-Year Event Allowing Change (mark one)				
	Mid-year Change Event	**Allowable Change**	**Supporting Documentation**	**When Coverage Begins and Ends**
☐	Birth	You may enroll yourself, spouse, spouse's child(ren), newborn, and any eligible dependents.	None	Retroactive coverage to the date of the birth if enrolled within 31 calendar days of the birth. You can also enroll after 31 calendar days but before the 61st calendar day from the date of birth; however, coverage will be effective on the date the paperwork is received by the Benefits Department.
☐	Adoption or placement for adoption	You may enroll yourself, spouse, spouse's child(ren), newly adopted eligible children, and any other eligible dependent(s).	You must submit the official placement agreement and/or official adoption papers upon enrollment.	Retroactive coverage to the date of the adoption or placement for adoption if enrolled within 31 calendar days of the adoption. You can also enroll after 31 calendar days but before the 61st calendar day from the date of adoption or placement for adoption; however, coverage will be effective on the date the paperwork is received by the Benefits Department.
☐	Legal Guardianship	You may enroll yourself, spouse, spouse's child(ren), newly eligible children, and any other eligible dependent(s).	You must submit the legal guardianship court papers granting permanent custody upon enrollment.	Coverage begins on the later of the date of the event creating eligibility or the date the Benefits Department receives completed paperwork.
☐	Marriage	You may enroll yourself, spouse, and any eligible dependent(s).	None	Coverage begins on the later of the date of the event creating eligibility or the date the Benefits Department receives completed paperwork.
☐	Spouse, spouse's child(ren), or eligible dependent(s) terminates employment or retires	You may enroll yourself, spouse, spouse's child(ren) or eligible dependent(s) who lose coverage	You must submit official documentation from employer verifying loss of coverage.	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage or the date the Benefits Department receives completed paperwork.
☐	Employee, spouse, spouse's child(ren), or eligible dependent(s) disenroll from an employer group plan during the open enrollment period that operates on a plan year other than a calendar year.	You may enroll yourself, spouse, spouse's child(ren), or eligible dependent(s) who lose coverage	You must submit official documentation from employer verifying loss of coverage.	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork.

B. Qualifying Enrollment Mid-Year Event Allowing Change (mark one)				
	Mid-year Change Event	**Allowable Change**	**Supporting Documentation**	**When Coverage Begins and Ends**

☐ Other:

Refer to Section 3 (Eligibility) and Section 4 (Mid-Year Enrollment/Disenrollment Events) in the Sandia Health Benefits Plan for Employees SPD for a complete list of qualifying events and supporting documentation requirements.

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

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.

First Name	Last Name	M. I.	Relation to Employee	SS (REQUIRED)*	Gender	Birth Date	Medical	Dental	Vision
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

A Social Security number for all dependents is **required**. Enrollment of your dependent will not occur unless we receive the Social Security Number.

***Exceptions:** Foreign spouses that do not have a Social Security Number and newborns/adoptions.

Important: Employees are required to report the dependent social security number to the Benefits Department once the newborn/adopted child's Social Security number is received.

NOTE: Employees or eligible dependents are not eligible to have double health plan coverage. Employees cannot be covered as both a primary participant and a dependent, or as a dependent under two different Sandia employees.

C. Qualifying Disenrollment/Waiver Mid-Year Event Allowing Change (mark one)				
	Mid-year Change Event	**Allowable Change**	**Supporting Documentation**	**When Coverage Begins and Ends**
☐	Judgment, decree or order which resulted from a divorce, legal separation, annulment, or change in legal custody, and must meet the requirements of a Qualified Medical Child Support Order (QMCSO).	You may disenroll the eligible dependent(s) consistent with the judgment, decree, or order.	You must submit the official judgment, decree or order upon enrollment.	Coverage ends on the last day of the month in which the event takes place.
☐	Event by which dependent ceases to satisfy eligibility requirements	You must disenroll dependent.	None	Coverage ends on the last day of the month in which dependent became ineligible **Note:** At the end of the month in which your dependent turns age 26, Sandia Benefits will generally disenroll the dependent. If your dependent was not automatically disenrolled, it is your responsibility to notify the Sandia Benefits Department. Refer to Section 10 (Continuation of Coverage) in the Sandia Health Benefits Plan for Employees SPD for information on COBRA coverage.
☐	Marriage	You may disenroll yourself and any enrolled dependents who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision).	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place.
☐	Death of spouse or dependent	You must disenroll spouse or dependent.	None	Coverage ends on the date of death.
☐	Spouse or eligible dependent(s) commences employment	You may disenroll yourself, spouse, and/or enrolled dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision).	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place.

C. Qualifying Disenrollment/Waiver Mid-Year Event Allowing Change (mark one)				
	Mid-year Change Event	**Allowable Change**	**Supporting Documentation**	**When Coverage Begins and Ends**
☐	Spouse or eligible dependent(s) have a change that makes them eligible for other coverage	You may disenroll yourself, spouse, or dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
☐	Spouse or eligible dependent(s) enrolls in an employer group plan during the open enrollment period that operates on a plan year other than a calendar year	You may disenroll yourself, spouse, or dependent(s) who enroll in a non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must submit documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
☐ Other: Refer to Section 3 (Eligibility) and Section 4 (Mid-Year Enrollment/Disenrollment Events) in the Sandia Health Benefits Plan for Employees SPD for a complete list of qualifying events and supporting documentation requirements.				

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

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

D. Employee Certification and Signature

Authorize Elections

I certify that the Class I dependent enrollment(s) elected with this action is in accordance with Sandia Corporate Policy Requirements as detailed in the Sandia Health Benefits Plan for Employees SPD. I also understand that I am responsible for disenrolling any dependents that become ineligible within 31 calendar days.

I understand that I must disenroll my ineligible dependent within 31 calendar days of the date that my dependent no longer meets the eligibility criteria for coverage under a Sandia medical, dental, or vision program.

If you do not disenroll your ineligible dependent, Sandia reserves the right to:

- Take employee disciplinary action up to and including termination for fraudulent use of the Sandia Health Benefits Plan for Employees SPD;
- Take action that results in permanent loss of coverage for you and your dependents for fraudulent use of the Sandia Health Benefits Plan for Employees SPD;
- Report the incident to the DOE Office of the Inspector General;
- Retroactively terminate dependent coverage to the extent permitted by law, effective the end of the month in which the dependent became ineligible;
- Hold the employee personally liable to refund to Sandia the cost of all medical, dental, and vision benefits provided during the ineligible period;
- Hold the employee personally liable to reimburse paid plan premiums for the current calendar year only; and
- Terminate any rights to temporary continued coverage under COBRA (if Sandia is not notified within 60 calendar days of what would have been the loss of coverage through Sandia).

I understand that failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

I agree to abide by the terms and conditions in the applicable Summary Plan Description concerning subrogation and right of recovery provisions.

I understand that if I waive coverage for myself and all of my dependents for medical, dental and vision that Sandia is not responsible for any health plan 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 healthcare plan will be during the Open Enrollment period for coverage beginning the next calendar year or based on an eligible mid-year election change event.

I agree that the information provided in this packet is true and correct to the best of my knowledge.

I authorize Sandia to increase or decrease my health care premium amount as applicable.

_____	_____	_____
Signature	SNL I.D.	Date

Submit this completed form along with any required documentation via one of the following methods:

Fax to HBE/Benefits at 505-844-7535, or
Mail, Attn: HBE/Benefits to MS-1022

This form must be received by Benefits **within 31 calendar days** of the mid-year election change event.
Contact Information: HBE Customer Service at 505-844-HBES (4237)

FOR BENEFITS USE ONLY	
Signature of Benefits representative	Date change entered in SNL database