MEDICAL/ DENTAL/ VISION ENROLLMENT / CHANGE FORM

NEW ENROLLMENTS only:

MEDICAL Benefit Elections are effective:

- **Option 1: The first day of the month after your completed Form is received and approved by the Benefits Department, *or***
- **Option 2: The date your completed Form is received and approved by the Benefits Department**

***Note**: Premiums will not be prorated regardless of the date your coverage becomes effective*

DENTAL AND VISION Benefit Elections are effective:
The first day of the month after your completed Form is received and approved by the Benefits Department

QUALIFYING CHANGE IN STATUS:

All benefit elections for Qualifying Change in Status events are effective the first day of the month after the completed Form is received and approved by the Benefits Department

---

Submit properly completed form to the HR Service Center at 1700 Lomas Blvd NE, Ste. 1400 or fax to 505-277-2278.

IMPORTANT NOTE: If you are enrolling dependents, you will be required to submit dependent verification documents. If you are making changes as a result of a Qualifying Life Event, you will be required to submit proof of event date documents, for more information go to https://hr.unm.edu/benefits/enrollment

Employee Information

Name (Last, First, MI)	Date of Birth	UNM Banner ID (Employee ID- 9 digits)
Preferred Email: _____ **Note: Your preferred email and mailing addresses in LoboWeb are used for Benefits enrollment records and communications; please ensure you are updated and current.**	Marital Status ☐ Married ☐ Single ☐ Domestic Partner	Is your spouse a UNM Employee? ☐ No ☐ Yes Spouse's Name:_____
Phone	Date of Hire	Spouse's Banner ID:_____

Type of Action (See hr.unm.edu/benefits/eligibility for required documentation and eligibility details)

☐ ENROLL	☐ CANCEL COVERAGE	☐ ADD DEPENDENT(S)	☐ CANCEL DEPENDENT(S)
☐ Newly Benefit Eligible *(on Medical select option 1 or 2)* ☐ Qualifying Life Event *(Medical Option 1 only)* ☐ Return from LWOP (Reinstatement of prior coverage only) *(Medical Option 1 only)* ☐ Other _____	☐ Qualifying Life Event ☐ LWOP ☐ Newly covered under other plan ☐ Death ☐ Other _____	☐ Qualifying Life Event ☐ Birth of Child (Medical coverage effective date of birth) ☐ Other _____ **(List Dependent(s) on Page 2**	☐ Divorce/Separation ☐ Dependent Ineligible (age) ☐ Qualifying Life Event - (within 60 calendar days of event) ☐ Other _____ **(List Dependent(s) on Page 2**

Medical Plan Election	Dental Plan Election	Vision Plan Election
☐ **Option 1** - Effective First of Next Month *(available for all action types)* ☐ **Option 2** - Effective Date Submitted *(Newly Benefit Eligible only)*	**Effective First of Next Month**	**Effective First of Next Month**
☐ UNM Team Health ☐ BlueCross BlueShield of NM ☐ Presbyterian Health Plan ☐ Employee Only (Single) ☐ Employee + Child(ren) ☐ Employee + Spouse or Domestic Partner ☐ Family (Employee, Spouse/Domestic Partner, Child(ren)) ☐ **Waive Medical**	☐ Delta Dental Premier (High) ☐ Delta Dental PPO (Low) ☐ Employee Only (Single) ☐ Employee + 1 (Double) ☐ Family (Employee, Spouse/Domestic Partner, Child(ren)) ☐ **Waive Dental**	☐ Vision Service Plan (VSP) ☐ Employee Only (Single) ☐ Employee + 1 (Double) ☐ Family (Employee, Spouse/Domestic Partner, Child(ren)) ☐ **Waive Vision**

-- This two page Form will not be accepted unless BOTH pages are completed --

BENEFITS

MEDICAL/ DENTAL/ VISION ENROLLMENT / CHANGE FORM

(CONTINUED)

Enrollees/ Dependents	Name (Last, First, MI)	DOB	Gender M / F	Action: (Add or Remove)	Mark Type of Coverage for each Enrollee
Spouse				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Domestic Partner (DP)				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
DP Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
DP Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision

Employee Certification

If you knowingly make a false statement on your Enrollment Application, or file a false claim, such application or claim may be retroactively rescinded to the date of the application or claim. Any premiums collected from the Participant for coverage that is later revoked due to a fraudulent application may be refunded to the Participant by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent application or claim, the Participant may be responsible for full reimbursement of the claim amount to UNM. I understand that my signature authorizes the University of New Mexico to make any necessary deductions from my pay through payroll deduction.

I understand and accept that if I fail to pay my account the University may refer my delinquent account to a collection agency. I further understand that I am responsible for paying the collection agency fee which may be based on percentage, at a maximum of 40% of my delinquent account, together with all costs and expenses, including reasonable attorney's fees, necessary of the collection of my delinquent account. Finally, I understand that my delinquent account may be reported to one or more of the national credit reporting bureaus.

It is your responsibility to review your **Benefits Statement in LoboWeb** and your paycheck benefit deductions. Report any issues or discrepancies to 277-MyHR (6947).

Signature: _____ **Date:** _____

HR SERVICE CENTER USE ONLY

HR Service Rep Initials: _____

Form Complete: ☐ Yes ☐ No
If no, reason: _____

Required Docs attached: ☐ Yes ☐ No
If no, reason: _____

HR BENEFITS USE ONLY

Appt %: _____ BCAT: _____

Annualized Salary: ☐<35 ☐ 35-50 ☐ >50

Coverage starts 1st of next month: _____

Medical Coverage starts immediately, date form submitted: _____

Deduction starts: _____