BENEFITS & EMPLOYEE WELLNESS

MEDICAL/ DENTAL/ VISION ENROLLMENT / CHANGE FORM

★ **Submit completed form to Benefits & Employee Wellness via Secure Document Upload *at https://hr.unm.edu/upload* or Fax to 505-277-2278 within 60 calendar days of the begin date of your newly benefits-eligible position or your Qualifying Change in Status Event. (Do not wait for proof documents, submit your completed form within your 60 calendar days)**

★ **Proof of Enrollment - *Save your Upload Successful page or your successful Fax transmission confirmation page.***

NEW ENROLLMENT and QUALIFYING CHANGE IN STATUS EVENT :

MEDICAL Benefit Elections are effective:

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

**** IMPORTANT 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 Office.

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)	UNM Banner ID (Employee ID- 9 digits)	Date of Hire
Preferred Phone (with area code)	Date of Birth	Is your Spouse/Domestic Partner a UNM Employee? ☐ No ☐ Yes
Preferred email **Note: Your preferred email and mailing address in LoboWeb are used for Benefits enrollment records and communications; please ensure they are updated and current.**		If Yes, Spouse/Domestic Partner Name: _____ Spouse's Banner ID: _____

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

☐ ENROLL

Within 60 calendar days of date of event below
- ☐ Newly Benefit Eligible *(for Medical select option 1 or 2)*
- ☐ Qualifying Change in Status *(for Medical select option 1 or 2)*
- ☐ Return from Leave without Pay (LWOP) (Reinstatement of prior coverage only) *(for Medical select option 1 or 2)*
- ☐ Other _____

☐ CANCEL COVERAGE

Within 60 calendar days of date of event below
- ☐ Qualifying Change in Status
- ☐ Leave without Pay (LWOP)
- ☐ Newly covered under other plan
- ☐ Death
- ☐ Other _____

☐ ADD DEPENDENT(S)

Within 60 calendar days of date of event below
- ☐ Qualifying Change in Status
- ☐ Birth of Child/Adoption (Medical coverage effective date of birth)
- ☐ Other _____

(List Dependent(s) on Page 2

☐ CANCEL DEPENDENT(S)

Within 60 calendar days of date of event below
- ☐ Divorce/Separation
- ☐ Dependent Ineligible (age)
- ☐ Qualifying Change in Status
- ☐ Other _____

(List Dependent(s) on Page 2

Medical Plan Election	Dental Plan Election	Vision Plan Election
☐ **Option 1** - Effective First of Next Month ☐ **Option 2** - Effective Date Submitted *(Full Monthly Premium Applies - see important note above)*	**Effective First of Next Month**	**Effective First of Next Month**
☐ UNM LoboHealth ☐ 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 & EMPLOYEE WELLNESS

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 *- You may not add a dependent who is currently enrolled in another UNM health plan (for example, UNM Student Health Plan, UNM Retiree Plan) -*
Spouse				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Child				☐ Add ☐ Remove	☐Medical ☐Dental ☐Vision
Child				☐ 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 hrbenefits@unm.edu.

* **IF UPLOADING ELECTRONICALLY TO HR'S SECURE DOCUMENT UPLOAD SITE, MY TYPED-IN NAME BELOW SERVES AS MY SIGNATURE.**
* **SIGNATURE IS REQUIRED IF PROVIDING PAPER FORM VIA FAX or MAIL.**

***Signature:** _____ **Date:** _____

BENEFITS & EMPLOYEE WELLNESS USE ONLY

BCAT: _____

Deduction starts _____ If Medical Coverage Option 2, date form submitted: _____

Benefits Rep Initials _____ **Uploaded/Received on** _____