

MEDICAL/ DENTAL/ VISION ENROLLMENT / CHANGE FORM

★ **Submit** completed form to UNM HR Benefits via [Secure Document Upload](https://hr.unm.edu/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 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 (newly benefits-eligible only)
- 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 EVENT:

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 with the exception of medical enrollment for birth/adoption which is effective the date of the event.

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? <input type="checkbox"/> No <input type="checkbox"/> Yes
Preferred email _____	If Yes, Spouse/Domestic Partner Name: _____	
Note: Your preferred email and mailing address in LoboWeb are used for Benefits enrollment records and communications; please ensure they are updated and current.		Spouse's Banner ID: _____

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

<input type="checkbox"/> ENROLL Within 60 calendar days of date of event below <input type="checkbox"/> Newly Benefit Eligible <i>(on Medical select option 1 or 2)</i> <input type="checkbox"/> Qualifying Change in Status <i>(Medical Option 1 only)</i> <input type="checkbox"/> Return from Leave without Pay (LWOP) (Reinstatement of prior coverage only) <i>(Medical Option 1 only)</i> <input type="checkbox"/> Other _____	<input type="checkbox"/> CANCEL COVERAGE Within 60 calendar days of date of event below <input type="checkbox"/> Qualifying Change in Status <input type="checkbox"/> Leave without Pay (LWOP) <input type="checkbox"/> Newly covered under other plan <input type="checkbox"/> Death <input type="checkbox"/> Other _____	<input type="checkbox"/> ADD DEPENDENT(S) Within 60 calendar days of date of event below <input type="checkbox"/> Qualifying Change in Status <input type="checkbox"/> Birth of Child/Adoption (Medical coverage effective date of birth) <input type="checkbox"/> Other _____ (List Dependent(s) on Page 2)	<input type="checkbox"/> CANCEL DEPENDENT(S) Within 60 calendar days of date of event below <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Dependent Ineligible (age) <input type="checkbox"/> Qualifying Change in Status <input type="checkbox"/> Other _____ (List Dependent(s) on Page 2)
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Medical Plan Election	Dental Plan Election	Vision Plan Election
<input type="checkbox"/> Option 1 - Effective First of Next Month <i>(available for all Action Types)</i> <input type="checkbox"/> Option 2 - Effective Date Submitted <i>(Newly Benefit Eligible only)</i>	Effective First of Next Month	Effective First of Next Month
<input type="checkbox"/> UNM LoboHealth <input type="checkbox"/> Presbyterian Health Plan <input type="checkbox"/> Employee Only (Single) <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse or Domestic Partner <input type="checkbox"/> Family (Employee, Spouse/Domestic Partner, Child(ren)) <input type="checkbox"/> Waive Medical	<input type="checkbox"/> Delta Dental Premier (High) <input type="checkbox"/> Delta Dental PPO (Low) <input type="checkbox"/> Employee Only (Single) <input type="checkbox"/> Employee + 1 (Double) <input type="checkbox"/> Family (Employee, Spouse/Domestic Partner, Child(ren)) <input type="checkbox"/> Waive Dental	<input type="checkbox"/> Vision Service Plan (VSP) <input type="checkbox"/> Employee Only (Single) <input type="checkbox"/> Employee + 1 (Double) <input type="checkbox"/> Family (Employee, Spouse/Domestic Partner, Child(ren)) <input type="checkbox"/> Waive Vision

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

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(CONTINUED)

Enrollees/ Dependents	Name (Last, First, MI)	DOB	Gender M / F	Action: (Add or Remove)	Mark Type of Coverage for each Enrollee
Spouse				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Domestic Partner (DP)				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
DP Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
DP Child				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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: _____

HR SERVICE CENTER USE ONLY	HR BENEFITS USE ONLY
HR Service Rep Initials: _____	BCAT: _____
Form Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason: _____	Salary: <input type="checkbox"/> <35 <input type="checkbox"/> 35-50 <input type="checkbox"/> >50 Deduction starts _____
Required Docs attached: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason: _____	If Medical Coverage Option 2, date form submitted: _____
	Benefits Rep Initials _____ Uploaded/Received on _____