

## RESIDENT PHYSICIAN MEDICAL, DENTAL & VISION Enrollment / Change Form

**You must submit the Enrollment / Change Form to UNM's Benefits & Employee Wellness office via Secure Document Submission Upload at <https://hr.unm.edu/upload> or fax 505-277-2278 within 60 calendar days of your first date of benefits-eligibility or Qualifying Change in Status Event.**

**Benefits will be effective the first day of the month after this Form is received and approved by Benefits & Employee Wellness**

**UNM's Benefits & Employee Wellness USE ONLY**

BCAT: \_\_\_\_\_  
 Downloaded/Received on \_\_\_\_\_  
 Annualized Salary:  <35     35-50     >50  
 Deduction starts: \_\_\_\_\_  
 Benefits Rep Initials \_\_\_\_\_

**Employee Information**

Name (Last, First, MI)	Date of Birth	UNM Banner ID (Employee ID- 9 digits)
Address	Gender	Marital Status
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Email: _____	Phone	Is your spouse a UNM Employee? (if applicable)
<p><b>Note: Your preferred email and mailing address in LoboWeb is used for Benefits enrollment records and communications. It is imperative that you review and update your demographic information in LoboWeb.</b></p>	Date of Hire	

**Type of ENROLLMENT Action (See [hr.unm.edu/benefits/eligibility](http://hr.unm.edu/benefits/eligibility) for required documentation and eligibility details)**

<input type="checkbox"/> CHANGE OR <input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> ADD DEPENDENT(S) List Dependent(s) Below	<input type="checkbox"/> CANCEL DEPENDENT(S) List Dependent(s) Below
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Medical Plan Election	Dental Plan Election	Vision Plan Election
<input type="checkbox"/> UNM House Officer BCBS Custom PPO Plan <input type="checkbox"/> Employee Only (Single) <input type="checkbox"/> Family (Employee, Spouse/Domestic Partner and/or Child(ren)) <input type="checkbox"/> Waive Medical	<input type="checkbox"/> Delta Dental Premier <input type="checkbox"/> Employee Only (Single) <input type="checkbox"/> Family (Employee, Spouse/Domestic Partner and/or Child(ren)) <input type="checkbox"/> Waive Dental	<input type="checkbox"/> Vision Service Plan (VSP) <input type="checkbox"/> Employee Only (Single) <input type="checkbox"/> Family (Employee, Spouse/Domestic Partner and/or Child(ren)) <input type="checkbox"/> Waive Vision

Dependents	Name (Last, First, MI)	Date of Birth	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
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.

- \* 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.

\* **Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

It is your responsibility to review your **Benefits Statement in LoboWeb** and your benefit deductions. Report any issues or discrepancies to [hrbenefits@unm.edu](mailto:hrbenefits@unm.edu) or 277-MyHR (6947).

**IMPORTANT NOTE:** If you are enrolling dependents, you will be required to submit dependent verification documents.

## PROOF DOCUMENTS SUBMISSION REQUIREMENTS

- If you are enrolling dependents in Medical, you will be required to submit Proof of their Eligibility to the Dependent Verification Center, who will contact you via a home mailing within a few weeks after enrollment with instructions on how and by when to submit your proof documents.
- If you are enrolling dependents in Dental and/or Vision, you must provide Proof of their Eligibility to UNM's Benefits & Employee Wellness office.

### **Newly Benefits Eligible:**

*Proof of Dependent Eligibility must be provided within 31 days after this Enrollment/Change Form has been received by UNM's Benefits & Employee Wellness office:*

**Secure Benefits Document Upload:** <https://hr.unm.edu/upload>

OR

**Fax:** (505) 277-2278

*Examples of proof documents required:* <https://hr.unm.edu/docs/benefits/open-enrollment-dependent-proof-document-requirements.pdf>

### **Qualifying Change in Status Events:**

1. *If you are enrolling dependents in Dental and/or Vision, you must provide Proof of their Eligibility to UNM's Benefits & Employee Wellness office:*

**Secure Benefits Document Upload:** <https://hr.unm.edu/upload>

OR

**Fax:** (505) 277-2278

2. *You must also provide Proof Documents to validate the Qualifying Event.*

*Examples of Qualifying Event proof documents required:* <https://hr.unm.edu/docs/benefits/required-qualifying-change-in-status-event-support-documentation.pdf>

*Proof of Dependent Eligibility must be provided within 31 days after this Form has been received by UNM's Benefits & Employee Wellness office.*

*For details about Qualifying Change in Status Events, go to:*

<https://hr.unm.edu/benefits/qualifying-change-in-status>

*You must submit this Enrollment/Change Form to UNM's Benefits & Employee Wellness office within the designated timeline below for your newly benefits-eligible position event or your Qualifying Change in Status Event*

- *Blue Cross Blue Shield House Officer PPO (medical):* **31** calendar days from event date

*Note: Special Enrollment rules apply if you initially waived medical coverage: 60 calendar days from event  
Applies only for these specific life events that result in a gain of a new dependent: birth of child, adoption, or marriage*

- *Delta Dental of New Mexico:* **60** calendar days from event date
- *Vision Service Plan (VSP):* **60** calendar days from event date
- *Flexible Spending Account (FSA):* **60** calendar days from event date
- *Guardian Life/Disability:* **Not applicable**, auto-enrolled as a new hire