



Benefits Enrollment Form

Return to Benefits Office:
 TA-3 Otowi Bldg. 261
 2nd Floor, MS P280
 Fax: 505-665-2156

Section I: Employee Information

Employee Name	Z Number	Date of Qualifying Event
Mailing Address (New Hires or Change of Address Only)	City, State, Zip	Qualifying Event

Section II: Health and Welfare Benefits Enrollment

(Note: Employees must be eligible for the plan they are choosing. Employees may review eligibility requirements in the [LANS Summary Plan Description](#))

<p>Medical</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my medical coverage <input type="checkbox"/> I am canceling/declining my medical coverage <input type="checkbox"/> No change <p>Type of Enrollment (select only one):</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/Same Sex Domestic Partner <input type="checkbox"/> Employee + Family <input type="checkbox"/> Modified Family (Employee + Children)	<p>Medical Plan Options</p> <p>Type of Enrollment (select only one):</p> <input type="checkbox"/> Blue Cross Blue Shield of New Mexico Preferred Provider Organization (PPO) <input type="checkbox"/> Blue Cross Blue Shield of New Mexico High-Deductible Health Plan (HDHP)
<p>Dental</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my dental coverage <input type="checkbox"/> I am canceling/declining my dental coverage <input type="checkbox"/> No change <p>Type of Enrollment (select only one):</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/Same Sex Domestic Partner <input type="checkbox"/> Employee + Family <input type="checkbox"/> Modified Family (Employee + Children)	<p>Vision</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my vision coverage <input type="checkbox"/> I am canceling/declining my vision coverage <input type="checkbox"/> No change <p>Type of Enrollment (select only one):</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/Same Sex Domestic Partner <input type="checkbox"/> Employee + Family <input type="checkbox"/> Modified Family (Employee + Children)
<p>Healthcare Reimbursement Account (HCRA) (Not eligible with HDHP enrollment)</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my HCRA account <input type="checkbox"/> I am canceling/declining my HCRA account <input type="checkbox"/> No change <p>HCRA Contribution Amount: \$ _____/year (Minimum \$180/Maximum \$2,500)</p>	<p>Health Savings Account (HSA) (Not eligible with PPO enrollment)</p> <p>Employees may review IRS HSA eligibility requirements</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my HSA <input type="checkbox"/> I am canceling/declining my HSA <input type="checkbox"/> No change <p>HSA Contribution Amount: \$ _____/per payroll deduction (Annual contribution limits: \$3,300 individual and \$6,550 family)</p>
<p>Dependent Care Reimbursement Account (DCRA) (Note: This account is used for eligible dependent daycare expenses)</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my DCRA account <input type="checkbox"/> I am canceling/declining my DCRA account <input type="checkbox"/> No change <p>DCRA Contribution Amount: \$ _____/year (Minimum \$180/Maximum \$5,000)</p>	<p>Adoption Expense Reimbursement Account (AERA)</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my AERA account <input type="checkbox"/> I am canceling/declining my AERA account <input type="checkbox"/> No change <p>AERA Contribution Amount: \$ _____/year (Minimum \$180/Maximum \$12,970)</p>
<p>Legal</p> <p>Type of Action (you must choose from the following):</p> <input type="checkbox"/> I am selecting/changing my legal coverage <input type="checkbox"/> I am canceling/declining my legal coverage <input type="checkbox"/> No change <p>Type of Enrollment (select only one):</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Adult <input type="checkbox"/> Employee + Family <input type="checkbox"/> Modified Family (Employee + Children)	

Note: This form shall be protected as LANS Employment Sensitive and/or LANS Employment Sensitive/PII when one or a combination of the following personal information is revealed in a LANS record: Education, salary, medical history, employment history, social security number, date and place of birth, or mother's maiden name.

Section II: Health and Welfare Benefits Enrollment (Cont.)

<p>Employee-Paid Supplemental Disability Insurance</p> <p>Type of Action (you must choose from the following):</p> <p><input type="checkbox"/> I am selecting/changing my supplemental disability insurance coverage (a Statement of Health is required for a decrease in elimination period)</p> <p><input type="checkbox"/> I am canceled/declining my supplemental disability insurance coverage</p> <p><input type="checkbox"/> No change</p> <p>Elimination Period (select only one):</p> <p><input type="checkbox"/> 7 days <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days</p>	<p>AD&D Enrollment Information</p> <p>Type of Action (you must choose from the following):</p> <p><input type="checkbox"/> I am selecting/changing my AD&D coverage</p> <p><input type="checkbox"/> I am canceled/declining my AD&D coverage</p> <p><input type="checkbox"/> No change</p> <p>Type of Enrollment (select only one):</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family</p> <p><input type="checkbox"/> Modified Family (Employee + Children Only)</p> <p>Level of Coverage (select only one):</p> <p><input type="checkbox"/> \$10,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$300,000</p> <p><input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$400,000</p> <p><input type="checkbox"/> \$30,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$500,000</p>
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<p>Employee-Paid Supplemental Life Insurance</p> <p>Type of Action (you must choose from the following):</p> <p><input type="checkbox"/> I am selecting/changing my life insurance coverage</p> <p><input type="checkbox"/> I am canceled/declining my life insurance coverage</p> <p><input type="checkbox"/> No change</p> <p>Type of Enrollment (select only one):</p> <p><input type="checkbox"/> \$20,000 <input type="checkbox"/> 3 Times Annual Salary</p> <p><input type="checkbox"/> 1 Times Annual Salary <input type="checkbox"/> 4 Times Annual Salary</p> <p><input type="checkbox"/> 2 Times Annual Salary <input type="checkbox"/> 5 Times Annual Salary</p>	<p>Employee-Paid Dependent Life Insurance</p> <p>Type of Action (you must choose from the following):</p> <p><input type="checkbox"/> I am selecting/changing my dependent life insurance coverage</p> <p><input type="checkbox"/> I am canceled/declining my dependent life insurance coverage</p> <p><input type="checkbox"/> No change</p> <p>Type of Enrollment (select only one):</p> <p><input type="checkbox"/> Spouse/Same Sex Domestic Partner Only</p> <p><input type="checkbox"/> Spouse/Same Sex Domestic Partner + Child(ren) Only <input type="checkbox"/> Child(ren) Only</p> <p>Level of Coverage (select only one):</p> <p><input type="checkbox"/> Basic Plan (\$5,000 for each dependent) <input type="checkbox"/> Expanded up to \$100,000</p> <p><input type="checkbox"/> Expanded \$10,000 (child only) <input type="checkbox"/> Expanded up to \$150,000</p> <p><input type="checkbox"/> Expanded up to \$50,000 <input type="checkbox"/> Expanded up to \$200,000</p> <p><input type="checkbox"/> Expanded up to \$75,000</p>
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Note: An employee cannot enroll in supplemental life insurance and be covered by another LANS employee (i.e. spouse, parent) under dependent life insurance (Basic or Expanded plan)

Section III: Eligible Family Member Actions

Instructions:

1. Indicate appropriate action code as follows: **E=Enroll, D=D-enroll, C=Change**
2. Enter the following information for ANY dependents (including yourself) for whom you are applying in an enrollment option: social security number (required), name, gender, and date of birth
3. Indicate the relationship code as follows:
Relationship Code Key: 2=Spouse, 3=Natural Child, 4=Adopted Child, 5=Same Sex Domestic Partner, 6=Same Sex Domestic Partner Child, 7=Stepchild, 8=Legal Ward
4. If dependent is currently in the LANL system (Contact, Child, Contractor, etc.) list Z #

Action	Social Security (Required)	Name (Last, First, MI)	Gender	Date of Birth	Relationship Code	If dependent is currently in the LANL system (Contact, Child, Contractor, etc.) list Z #

Terms and Conditions

By signing this form, I agree to the following Terms and Conditions: The LANS Benefit Office reserves the right to request additional enrollment information, including, but not limited to, birth certificates, tax documentation, social security numbers, and any other information deemed necessary. The LANS Benefit Office also reserves the right to cancel coverage for ineligible dependents in cases where enrollment is contrary to the LANS Health & Welfare Benefits Plan for Active Employees. It is my responsibility to verify my enrollment is correct. Any incorrect or missing enrollments must be identified to the Benefits Office in writing within 31 days of the Life Event. By signing this form, I authorize deductions from my earnings to cover premiums, if any, for the plans I have selected for my eligible family members and myself. This authorization will remain in effect until I submit another form changing, canceling, or opting out of coverage in conjunction with an eligible Life Event. **Dependency Affidavit:** By attempting enrollment of any of the above, I certify the child(ren) listed in the Eligible Family Member Actions section are under the age of 26 if enrolled in Medical or Dental, under the age of 25 and unmarried if enrolled in Vision, and under the age of 23 and unmarried if enrolled in any other plan (unless disabled and eligible to continue coverage past age 23), or under age 18 if a legal ward. I certify that legal ward(s) listed are unmarried, living with me, a dependent of mine for at least 50% support, and declared as my dependent(s) on my income tax returns. **Misuse of Plans:** LANS reserves the right to de-enroll individuals and their family members who misuse the Plan. Misuse of the Plan includes, but is not limited to, actions such as falsifying enrollment or claims information, allowing others to use Plan identification cards, enrollment of ineligible dependents, and threats or abusive behavior towards Plan providers or representatives. Insurance carriers may have their own rules that apply to misuse of the insured Benefit Program in which you are enrolled. I understand that I will be liable for all costs incurred as a result of invalid enrollments.

Employee Signature:	Z Number:	Date:
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