



The University of New Mexico

HEALTH / DENTAL/ VISION ENROLLMENT / CHANGE FORM

Effective Date: _____

Type: _____

HR USE ONLY

Employee Information				
Name (Last, First, MI)		Date of Birth	Social Security Number	
Home Address		Gender	Marital Status	
		<input type="checkbox"/> Male	<input type="checkbox"/> Married	
		<input type="checkbox"/> Female	<input type="checkbox"/> Single	
			<input type="checkbox"/> I have a Domestic Partner	
			Note: Copy of Marriage Certificate or Domestic Partner Affidavit will be required.	
Work Location (Department)	Day Time Phone	Work Phone	Date of Hire	Is your spouse a UNM Employee? (if applicable)
				<input type="checkbox"/> Yes - SSN: _____
				<input type="checkbox"/> No

Type of Action			
<input type="checkbox"/> ENROLL	<input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> ADD DEPENDENT(S)	<input type="checkbox"/> CANCEL DEPENDENT(S)
<input type="checkbox"/> New Employee	<input type="checkbox"/> Terminated Employment	<input type="checkbox"/> Qualifying Life Event	<input type="checkbox"/> Divorce/Separation
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Dependent Ineligible (age) (marriage)
<input type="checkbox"/> Qualifying Life Event	<input type="checkbox"/> Qualifying Life Event	<input type="checkbox"/> Other _____	<input type="checkbox"/> Open Enrollment
<input type="checkbox"/> Retirement	<input type="checkbox"/> Death		<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	List Dependent(s) Below]	[List Dependent(s) Below]

Health Insurance Election	Dental Insurance Election	Vision Insurance Election
<input type="checkbox"/> Lovelace Custom Care Plan - Group #20002300	<input type="checkbox"/> Delta Dental Premier (High) - Group #1180	<input type="checkbox"/> Vision Service Plan
<input type="checkbox"/> United HealthCare Plan - Group #708058	<input type="checkbox"/> Delta Dental Preferred (Low) - Group #1180	Group#1206176
<input type="checkbox"/> Single (Employee Only)	<input type="checkbox"/> Single (Employee Only)	<input type="checkbox"/> Single (Employee Only)
<input type="checkbox"/> Single (Employee) + Child(ren)	<input type="checkbox"/> Employee + 1 (Double)	<input type="checkbox"/> Employee + 1 (Double)
<input type="checkbox"/> Employee + Spouse (or Domestic Partner)	<input type="checkbox"/> Family (Employee, spouse/domestic partner, child(ren))	<input type="checkbox"/> Family (Employee, spouse/domestic partner, child(ren))
<input type="checkbox"/> Family (Employee, spouse/domestic partner, child(ren))		
Will you have other Health Insurance Coverage?	Will you have other Dental Insurance Coverage?	Will you have other Vision Insurance Coverage?
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Yes - Plan Name/Group#	<input type="checkbox"/> Yes - Plan Name/Group#	<input type="checkbox"/> Yes - Plan Name/Group#
_____	_____	_____

Dependents	Name (Last, First, MI)	DOB	SSN#	Gender M/F
Spouse				
Child				
Child				
Child				
Domestic Partner (DP)				
DP Child				
DP Child				

Employee Certification
<p>I have read the descriptive literature outlining my selected health plan and I hereby apply on my behalf and on behalf of person(s) listed on this form for participation in said plan. I understand and accept that covered services will only be provided by the specific health care providers and institutions participating in or authorized by the carrier. I authorize my employer to deduct from my earnings the employee's contribution to the premium under the contract. I authorize my carrier to obtain information from providers of services to me and any spouse, domestic partner or dependents listed above, necessary for administration of my contract with my carrier. I further authorize my carrier to provide these records, as required, to any parties that are financially responsible for paying for the care rendered. Any person who knowingly presents a false statement or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. I understand that falsification of any information on this form may be grounds for cancellation of coverage.</p>
<p>Signature _____ Date: _____</p>