Los Alamos NATIONAL LABORATORY

Form 1751a

Open Enrollment 2022

Benefits Enrollment

Return completed form to LANL Benefits Office:
Fax: 505-665-2156
Email: benefits@lanl.gov

Section I: Employee Information

All fields on this form are required; please indicate "No Change" if you do not wish to change your plan or "waive" if you want to decline the coverage.

Employee Name	Z Number	Date of Life Event

Note: Insurance cards will be mailed to the address on file. If your address has changed, please email rr-desk@lanl.gov.

Life 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 Triad Summary Plan Description.

Medical

Type of Action (*you **must** choose from the following*):
- ☐ Elect, Change, Add, or Drop Dependent
- ☐ Waive
- ☐ No Change

Type of Enrollment (*if enrolling, select only one*):
- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner (only)
- ☐ Employee + Family ☐ Employee + Children (only)

Blue Cross Blue Shield of New Mexico Medical Plan Options

Plan Option (*if enrolling, select only one*):
- ☐ Preferred Provider Organization (PPO)
- ☐ High-Deductible Health Plan (HDHP)

Employees on a J-1 Visa must select PPO to meet coverage requirements.

Dental

Type of Action (*you **must** choose from the following*):
- ☐ Elect, Change, Add, or Drop Dependent
- ☐ Waive
- ☐ No Change

Type of Enrollment (if enrolling, select only one):
- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner (only)
- ☐ Employee + Family ☐ Employee + Children (only)

Vision

Type of Action (*you **must** choose from the following*):
- ☐ Elect, Change, Add, or Drop Dependent
- ☐ Waive
- ☐ No Change

Type of Enrollment (*if enrolling, select only one*):
- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner (only)
- ☐ Employee + Family ☐ Employee + Children (only)

Healthcare Reimbursement Account (HCRA)
(Available only with PPO or waived medical coverage)

Type of Action (you **must** choose from the following):
- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

HCRA Annual Contribution Amount: $_____/year
(2021 annual maximum: $2,750)
This plan requires you to re-elect this option every year per IRS rules.

Health Savings Account (HSA)
(Available only with HDHP medical coverage)

Type of Action (*you **must** choose from the following*):
- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

HSA Contribution Amount: $_____/per pay period
(2022 annual maximum: individual $3,650; family $7,300)

Dependent Care Reimbursement Account (DCRA)
Note: This account is used for eligible dependent daycare expenses.

Type of Action (*you **must** choose from the following*):
- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

DCRA Annual Contribution Amount: $_____/year
(2021 annual maximum: $5,000)
This plan requires you to re-elect this option every year per IRS rules.

Adoption Assistance Expense Account (AAEA)

Type of Action (*you **must** choose from the following*):
- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

AAEA Annual Contribution Amount: $_____/year
(2021 annual maximum: $14,440)
This plan requires you to re-elect this option every year per IRS rules.

Legal

Type of Action (*you **must** choose from the* following):
- ☐ Elect, Change, Add, or Drop Dependent
- ☐ Waive
- ☐ No Change

Type of Enrollment (*if enrolling, select only one*):
- ☐ Employee Only ☐ Employee + Spouse/Domestic Partner (*only*)
- ☐ Employee + Family ☐ Employee + Children (*only*)

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

Supplemental Short-Term Disability

Type of Action (*you **must** choose from the following*):

- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

Long-Term Disability

Type of Action (*you **must** choose from the following*):

- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

Note: Supplemental Short-Term Disability and/or Long-Term Disability may only be elected at Open Enrollment and will require Evidence of Insurability but can be waived at any time. Eligible new hires are automatically enrolled.

Employee Supplemental Life Insurance

Note: Enrolling/increasing coverage requires Evidence of Insurability.

Type of Action (*you **must** choose from the* following):

- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

Level of Coverage (*if enrolling, select only one*):

- ☐ 1 Time Annual Salary
- ☐ 2 Times Annual Salary
- ☐ 3 Times Annual Salary (GIA)
- ☐ 4 Times Annual Salary
- ☐ 5 Times Annual Salary
- ☐ 6 Times Annual Salary
- ☐ 7 Times Annual Salary
- ☐ 8 Times Annual Salary

Spouse Life Insurance

Note: Enrolling/increasing coverage requires Evidence of Insurability.

Type of Action (*you **must** choose from the following*):

- ☐ Elect/Change
- ☐ Waive
- ☐ No Change

Level of Coverage (*if enrolling, select only one*):

- ☐ $25,000
- ☐ $50,000 (GIA)
- ☐ $75,000
- ☐ $100,000
- ☐ $125,000
- ☐ $150,000
- ☐ $175,000
- ☐ $200,000

Child Life Insurance

Type of Action (*you **must** choose from the following*):

- ☐ Elect, Change, Add, or Drop Dependent
- ☐ Waive
- ☐ No Change

Level of Coverage (*if enrolling, select only one*): ☐ $5,000 ☐ $10,000 per child

Accidental Death and Dismemberment (AD&D)

Type of Action (*you **must** choose from the following*):

- ☐ Elect, Change, Add, or Drop Dependent
- ☐ Waive
- ☐ No Change

Type of Enrollment (*if enrolling, select only one*):

- ☐ Employee Only
- ☐ Employee + 1
- ☐ Employee + 2 or more

Level of Coverage (*if enrolling, select only one*):

- ☐ $50,000
- ☐ $100,000
- ☐ $200,000
- ☐ $300,000
- ☐ $400,000
- ☐ $500,000

Section III: Eligible Family Member Actions

Enter the required information below.

1. Indicate appropriate action code as follows: **Action Code Key:** E=Enroll, D=De-enroll
2. Indicate the relationship code as follows: 2=Spouse, 3=Natural Child, 4=Adopted Child, 5=Domestic Partner, 6=Domestic Partner Child, 7=Stepchild, 8=Legal Ward

Action Code	Social Security (Required) Note: Not required for newborn enrollment. Must call LANL Benefits Office to update when received.	Name (Last, First, MI)	Gender	Date of Birth	Relationship Code	Eligibility documentation for each dependent is required. Is documentation attached?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Terms and Conditions

By signing this form, I agree to the following Terms and Conditions: The LANL Benefits 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 LANL Benefits Office also reserves the right to cancel coverage for ineligible dependents in cases where enrollment is contrary to the Triad Welfare Benefit Plan for 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 calendar 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 meet the eligibility requirements as outlined in the Triad Welfare Benefit Plan for Employees. **Misuse of Plans:** Triad 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/Date (*Please sign with a pen, stylus, or use a signature with a date and timestamp included*)	Z Number