



VISION INSURANCE Enrollment/Change Form

Effective date for VSP is 1st of next month after enrollment form is received in HR

HR USE ONLY

Appt %: _____
 Annualized Salary: _____
 EClass: _____ Emp. Group: _____
 Coverage Effective Date: _____
 Deduction Begin Date: _____

Employee Information (Please print information clearly)

Name (Last, First, MI)		Date of Birth	UNM ID
Home Address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <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)	Email	Work Phone	Date of Hire
			Is your spouse a UNM Employee? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No

Type of Action – Check the type of action being requested (See reverse for allowable changes and effective dates of coverage)

<input type="checkbox"/> ENROLL	<input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> ADD DEPENDENT(S)	<input type="checkbox"/> CANCEL DEPENDENT(S)
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Reason for Action - Indicate the reason that allows enrollment or change in coverage

<input type="checkbox"/> New Employee (60-Day Eligibility Period) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Enrollment (transfer to benefits eligible assignment – 60 day period) <input type="checkbox"/> Birth of Child (must enroll /add within 31 days of birth) <input type="checkbox"/> Adoption/Guardianship of Child (Must enroll within 31 days of event) <input type="checkbox"/> Marriage/Domestic Partnership (must enroll/add within 31 days of event) <input type="checkbox"/> Divorce/Legal Separation/ Dissolution of Domestic Partnership (must enroll/cancel within 31 days of event)	<input type="checkbox"/> Loss of Coverage under other Non-UNM plan (other employer plan) <input type="checkbox"/> Newly Covered under other Non-UNM plan (other employer plan) <input type="checkbox"/> LWOP – Cancel Coverage <input type="checkbox"/> Return from LWOP – (must enroll within 31 days of return) <input type="checkbox"/> Change in FTE – Decrease (Cancel Coverage) <input type="checkbox"/> Change in FTE – Increase (Enroll) <input type="checkbox"/> Permanent Change of Residence - Outside of US (cancel coverage) <input type="checkbox"/> Dependent(s) Turned 25 (Cancel Coverage)
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Vision Insurance Election - Vision Service Plan Group Number 12061796, Division 003, Class 003

Check Level of Coverage (or new coverage level as applicable)

Employee Only
 Double (Employee + 1)
 Family (Employee + 2 or more)

Identify all Dependents being enrolled/covered under plan selected OR Identify only those dependents being added or cancelled if making a change.

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

Employee Certification

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.

Signature _____ Date: _____

When Coverage Begins / Ends

New Enrollments (New Hire/New Eligibility) - The effective date of coverage is the first day of the next month after the enrollment form is received in HR. Enrollment form must be received in HR within the 60-day enrollment eligibility period. Effective date for VSP can only be on the first day of the month.

New Enrollment (Previously Declined Coverage) – Under HIPPA, if an employee has previously opted out of health insurance coverage, he/she may enroll upon marriage or upon birth or adoption of a child. The employee can enroll for health, dental or vision coverage and add the new spouse or child. The effective date is the first day on the next month after enrollment form is received in HR. Enrollment form must be received within 31 days of the qualifying event.

Open Enrollment – Open enrollment occurs once each year typically during the first two weeks in May. An employee may enroll in any plan if not enrolled, cancel coverage or dependents, or make changes from one plan to another. Open enrollment changes become effective on July 1. If you are adding a Domestic Partner during open enrollment you must submit the required documentation as specified under UNM Business Policy 3790.

Adding Dependents (children/spouse) – The effective date is the first day of the month after enrollment form is received. Enrollment form must be received in HR within 31 days of birth or date legal adoption/guardianship became effective, or within 31 days of marriage.

Adding Dependents (Domestic Partner) – Domestic Partners must meet the criteria as specified under UNM Policy 3790. If you have recently completed 12 months in partnership as specified in the policy, you must submit your enrollment form within 31 days of the completed 12 month period. If you have had an ongoing partnership of more than 12 months, you can only add a domestic partner during open enrollment. Children of domestic partners are also eligible for coverage.

Terminations – The effective date of termination is the last day of the month in which employee separates from UNM. Premiums will be due/owed for the month in which the employee terminates. Dependents turning 25 will be automatically terminated on the last day of the month in which he/she reaches age 25. In the case of a divorce or dissolution of a domestic partnership, the ex-spouse or ex-domestic partner's coverage will end on the last day of the month in which the divorce was finalized or the dissolution of partnership became effective. . Note: Some dependents may be eligible beyond age 25 if they are disabled. Contact your insurance carrier for requirements to continue coverage beyond age 25 for eligible children.

Cancellations – The effective date is generally the last day of the month. However, the date may be a specified date if cancellation is being coordinated with other coverage being received, e.g., coverage being picked up by spouse's employer or employee is entering a Leave Without Pay (LWOP) status. Premiums will be due/owed for the month that coverage remains effective.

Re-enrollment after a period of LWOP – Employee must re-enroll within 31 days of returning back to pay status. The effective date will be the first day of the next month after enrollment form is received in HR.

Deductions – Deductions for premiums occur on the pay date that corresponds with the month that coverage became effective. For example, a monthly paid employee who's coverage became effective on March 1, will be deducted on their paycheck (pay date) of March 31. A biweekly paid employee will be deducted in the first pay date that includes/corresponds with the date the coverage became effective.

Employee Responsibilities and Required Documentation

Employees are responsible for submitting an enrollment form and/or change within the allowable eligibility period or qualifying change in status. If supporting documentation is not immediately available, at a minimum, the enrollment form should be submitted and supporting documentation submitted as soon as available.

Divorce / Dissolution of Domestic Partnership – Employees are required to submit a change form canceling coverage for a former spouse or domestic partner. In the case of a divorce, a copy of the final divorce decree must be submitted with the change form. In the case of dissolution of domestic partnership, a copy of the UNM "Termination of Domestic Partnership" form must be attached.

Birth of Child – Employee must provide hospital documentation or other acceptable documentation that verifies date of birth. This should be submitted with enrollment change form. *Note: You should submit enrollment form within 31 days even if you do not have required documentation and inform HR that documentation will follow.*

Adoption/Guardianship – Employee must attach a copy of legal adoption or assignment of guardianship that includes the effective date of the action. This should be attached to the enrollment change form.

Canceling Dependents – If canceling an otherwise eligible dependent child due to he/she acquiring their own coverage (own employer plan or other parent), include a copy of documentation that verifies other coverage. If child loses eligibility due to marriage, submit proof of child's marriage.