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Los Alamos NATIONAL LABORATORY

Form 2048

Casual/Benefits Eligibility Level Indicator (BELI6) Benefits Enrollment

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

Section I: Employee Information

Name (*Last, First, Middle Initial*)	Z Number	Date of Hire

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

Section II: Health and Welfare Benefit Elections

Please make your selections.

Plan (*you must choose one*):
- ☐ Elect Medical—HDHP
- ☐ Waive Coverage

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

Section III: Eligible Dependents and Coverage Elections

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?**
		Male			☐Yes ☐No
		Male			☐Yes ☐No
		Male			☐Yes ☐No
		Male			☐Yes ☐No
		Male			☐Yes ☐No

*Relationship code: 2 = Spouse, 3 = Natural Child, 4 = Adopted Child, 5 = Domestic Partner, 6 = Domestic Partner Child, 7 = Stepchild, 8 = Legal Ward

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 toward 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 or stylus, or use a signature with a date and timestamp included.*)	Z Number

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