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City of Albuquerque and Participating Entities
Medical, Dental and Vision Insurance Enrollment and Change Form

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Social Security Number	Employee Name: First, Middle Initial, Last		Sent to Vendors ☐ Sent to Cobra ☐	Effective Date
Employee ID	Mailing Address		Birth Date	Date of Hire
Gender (Circle One): Female or Male	City, State, Zip	Home email	Home Phone	Work Phone

2ER

EMPLOYER

☒ Sandoval County ☐ ABCWUA

☐ Belen	☐ Town of Bernalillo	☐ Vill. of Bosque Farms	☐	Village of Los Ranchos
☐ MRGCD	☐ Town of Cochiti Lake	☐ Village of Corrales	☐	Village of San Ysidro
☐ SSCAFCA	☐ Town of Edgewood	☐ Village of Cuba	☐	Village of Tijeras
	☐ Town of Mountainair	☐ Village of Jemez Springs	☐	ABQ Housing Auth.

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CERTIFICATION - You cannot cancel or change coverage without the qualifying event of a valid life status change.

Medical Insurance	☐ Decline	**Dental Insurance**	Enroll	Cancel	**Vision Insurance**	Enroll	Cancel	**For Office Use Only**
		Delta Dental 2517-00__	☐	☐	Davis Vision	☐	☐	Medical
Presbyterian 1365-H0__	Enroll	Cancel						Dental
Active Option	☐	☐						Vision
Family Option	☐	☐						
Independent Option	☐	☐						
Gym Membership	☐	☐						

Qualifying Event/Reason for Declination (New Hire, Marriage, Birth, Open Enrollment, etc

Action (Enroll, Add Dependent, Change Plans, etc.):

Event Date:

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Dependent Full Name	Relationship to Employee	Social Security Number	Date of Birth MM-DD-YY	Gender F or M	Insurance Enrollment **A** (add) or **C** (cancel) Medical	Dental	Vision	**Office Use** Eligible?	Eligibility Verified by

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I hereby submit the information on this form as application/change to insurance coverage under a plan contracted by the City of Albuquerque. I have received and read descriptive literature of the insurance plans as they affect this application/change. I understand, accept and agree to abide by the terms and provisions of the city agreement in receiving services. I understand that membership may be automatically terminated if I have intentionally given any false information regarding myself and/or my dependents on this application. I authorize the insurance carrier to disclose medical information concerning me, or my dependents, to authorize agencies when required under appropriate Federal/State legislation or regulation, and to obtain medical information from other appropriate agencies for the purpose of providing necessary health care/administrative services under the plan. I understand that the employer may change my premiums and/or benefits as part of the annual contract renewal process. I authorize my employer to reduce my earnings by the amount required to pay my share of insurance premiums including the recovery of premiums not paid due to retroactive coverage or a period of unpaid leave.

I understand I must provide documentation of dependent eligibility before their coverage will be effective.

X

Employee Signature	Date Signed		Accepted by	Entered by	Checked by	