ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT – EMPLOYEES ONLY
HEALTH AND WELFARE PLANS (rev. 10/2022)
Lawrence Livermore National Security, LLC (LLNS) Human Resources and Benefits

Fill in all pertinent information. **Send this form to the LLNS Benefits Office by email: llnl-benefits@llnl.gov or Lab Mail: L-642**

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	EMPLOYEE I.D. NO.	PHONE or PAGER (###) ###-####

2. EMPLOYEE ACTIONS

Check all that apply, write in date of event (if applicable):

ENROLL		CANCEL		CHANGE	
☐ Hire/Rehire	(date: _____)	☐ Cancel coverage indicated below	(date: _____)	☐ Change coverage indicated below	(date: _____)
☐ Change in appointment status	(date: _____)	☐ Divorce/legal separation/annulment	(date: _____)	☐ Open Enrollment	(date: Jan 1st)
☐ Birth/Adoption	(date: _____)	☐ Termination Registered Domestic Partnership	(date: _____)	☐ Statement of Health (life/disability only)	(date: _____)
☐ Marriage/Registered Domestic Partnership	(date: _____)	☐ Marriage/Registered Domestic Partnership	(date: _____)	☐ Statement of Health Submitted to Carrier	
☐ Involuntary loss of coverage	(date: _____)	☐ Death	(date: _____)	☐ Move out/return to plan's service area	(date: _____)
☐ Return from leave/furlough	(date: _____)	☐ Loss of dependent eligibility	(date: _____)	☐ Personal data for eligible dependent	(date: _____)
☐ Other (explain in comments box below)	(date: _____)	☐ Other (explain in comments box below)	(date: _____)	☐ Other (explain in comments box below)	(date: _____)

COMMENTS:

2A. OPT OUT OF LLNS-SPONSORED COVERAGE

I wish to decline coverage under the following LLNS-sponsored plans:

☐ Medical ☐ Dental ☐ Vision

I am declining this coverage because (check one):

☐ I am currently covered as an eligible family member or retiree under a LLNS-sponsored plan(s). Covered participant's Social Security No.:_____

☐ I am currently covered under a non-LLNS-sponsored group plan(s).

☐ Of my religious beliefs.

I understand that if I opt out of LLNS-sponsored medical, dental, or vision coverage, LLNS will not provide me or my family members with coverage.

3. MEDICAL, DENTAL, VISION, LEGAL, HCRA AND DCRA

To enroll in any of the plans listed below, mark the "Enroll" box. To change a plan, mark the "Cancel" box for your existing plan and mark the "Enroll" box for your new plan. If you cancel coverage for yourself, your enrolled family members will also be de-enrolled.

MEDICAL

Kaiser – North 1	☐Enroll	☐Cancel
Kaiser – South 1	☐Enroll	☐Cancel
Kaiser CA HDHP North1	☐Enroll	☐Cancel
Kaiser CA HDHP South 1	☐Enroll	☐Cancel
Anthem Blue Cross EPO	☐Enroll	☐Cancel
Anthem Blue Cross PLUS	☐Enroll	☐Cancel
Anthem Blue Cross PPO	☐Enroll	☐Cancel
Anthem Blue Cross Core Value	☐Enroll	☐Cancel
Anthem Blue Cross HDHP	☐Enroll	☐Cancel

1 You must live in the plan's service area

HSA Election:
Applies only if enrolled in ***Kaiser HDHP, Anthem Blue Cross HDHP*** or ***Anthem Blue Cross Core Value*** plan

HSA Employee payroll election:

$_____ (new annual amount)

Your pay period contribution will be calculated by dividing the annual amount you elected (minus any contributions already made) by the remaining deduction pay periods in the calendar year.

DENTAL

Delta Dental PPO
☐Enroll
☐Cancel/Waive

Delta Care USA (CA residents only)
☐Enroll
☐Cancel/Waive

VISION

Vision - Basic
☐Enroll
☐Cancel/Waive

Vision – Buy-up Option (Plus)
☐Enroll
☐Cancel/Waive

LEGAL

MetLife Legal Basic
☐Enroll
☐Cancel/Waive

MetLife Legal Enhanced
☐Enroll
☐Cancel/Waive

MetLife Legal Enhanced w/Parents
☐Enroll
☐Cancel/Waive

HEALTHCARE REIMBURSEMENT ACCOUNT (HCRA) & DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA) –

Note: You must re-enroll in this benefit each year.

☐ Enroll
☐ Cancel/Waive
☐ Change Contribution Amount

If mid-year event not listed in Section 2, refer to page 4 and enter appropriate code:

DCRA Code: _____ (for example: C-2)

Your contribution will be calculated by dividing the annual amount you elected (minus any contributions already made) by the remaining deduction pay periods in the calendar year.

Enter your new annual amount:

HCRA $ _____

DCRA $ _____

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	EMPLOYEE I.D. NO.	PHONE or PAGER (###) ###-####

4. OTHER INSURANCE PLANS – SEE FORM INTRODUCTION FOR INFORMATION ON NAMING BENEFICIARIES FOR LIFE INSURANCE AND AD&D PLANS

Employee Only

SUPPLEMENTAL DISABILITY

☐ Enroll
☐ Cancel
☐ Change
Waiting Period

(Check one):
☐ 7 days
☐ 30 days
☐ 90 days
☐ 180 days

(NOTE: You will be required to submit a Statement of Health to increase your coverage level.)

SUPPLEMENTAL LIFE INSURANCE

☐ Enroll
☐ Cancel
☐ Change

(NOTE: You will be required to submit a Statement of Health to increase your coverage level.)

(Check one):
☐ 1 Time Annual Salary
☐ 2 Times Annual Salary
☐ 3 Times Annual Salary
☐ 4 Times Annual Salary
☐ 5 Times Annual Salary
☐ Flat Amount ($20,000)

BASIC LIFE (LLNS paid)

☐ $50,000 coverage
(opt out of 1 Times Annual Salary)
☐ increase to 1-time Annual Salary

Eligible family members

DEPENDENT LIFE INSURANCE

☐ Enroll
☐ Cancel
☐ Change

(NOTE: You will be required to submit a Statement of Health to increase your coverage level.)

(*Coverage can't exceed employee's insured amount under Supplemental Life Insurance)

(Check one):
☐ Basic Plan ($5,000 for each dependent)
☐ Dependent Life –Spouse/ Registered Domestic Partner Only
Amount: $_____*
(Increments of $10,000; maximum of $200,000
☐ Dependent Life – Child(ren) Only ($10,000)

ACCIDENTAL DEATH & DISMEMBERMENT

☐ Enroll
☐ Cancel
☐ Change

(Check one):
☐ Self
☐ Family
☐ Modified Family

COVERAGE AMOUNT (Check one):

☐ $10,000	☐ $70,000	☐ $175000
☐ $20,000	☐ $80,000	☐ $200,000
☐ $30,000	☐ $90,000	☐ $300,000
☐ $40,000	☐ $100,000	☐ $400,000
☐ $50,000	☐ $125,000	☐ $500,000
☐ $60,000	☐ $150,000	

5. ELIGIBLE FAMILY MEMBER ACTIONS

Complete this section to: (1) enroll or de-enroll an eligible family member in the medical, dental, vision, and/or legal plans or (2) change personal data (e.g., correct a misspelled name or provide a Social Security number). Also check the appropriate box in section 2. In the Action box, check **"Enroll"** or **"De-enroll"**, and check the appropriate insurance plan box. If you are enrolling or de-enrolling family members, show the date of the event (marriage, birth, adoption, divorce, death, or registered domestic partnership or termination of partnership).

Relationship Codes: Enter the appropriate code to indicate the family member's relationship to you.
Adults: You may only enroll one eligible adult other than yourself: Spouse (**S**), Registered domestic partner (**D**).
Children: child (natural, adopted, or overage disabled*) (**C**), Stepchild (**P**), Legal ward (**W**), Foster Child (**F**), Registered domestic partner's child* (**K**).
* Must be a tax dependent

Action	Date of Event (2-digit year)	Name (Last, First, MI)	Sex	Relationship (use codes)	Birth Date (2-digit year)	Social Security Number (required)	Med	Dent	Vis	Leg
ADULTS –										
Check E or D below	MO DY YR	LISTED IN SECTION 1		SELF	MO DY YR	LISTED IN SECTION 1	LISTED IN SECTION 3			
☐ Enroll ☐ De-enroll							☐	☐	☐	☐
CHILDREN –										
☐ Enroll ☐ De-enroll						leave blank	☐	☐	☐	☐
☐ Enroll ☐ De-enroll							☐	☐	☐	☐
☐ Enroll ☐ De-enroll							☐	☐	☐	☐
☐ Enroll ☐ De-enroll							☐	☐	☐	☐

My signature below indicates I have read and agree to the "Terms and Conditions" on the back of this form. I declare under penalty of perjury under the laws of the state of California that all of the above information is true and correct.

EMPLOYEE'S SIGNATURE	DATE	SYSTEM UPDATED BY	DATE

SEE NEXT PAGE FOR PRIVACY NOTIFICATIONS

RETN: Accounting: 5 years following separation. In cases involving disability, retirement, or disciplinary action, retain until age 70. Other copies: 0-5 years after separation.

KAISER PERMANENTE®

California Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

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HEALTH AND WELFARE PLANS (rev. 10/2022)

Lawrence Livermore National Security, LLC (LLNS) Human Resources and Benefits

Use this form to enroll in, change, cancel, or opt out of insurance plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, contact the LLNS Benefits Office.

If the only action you require is to enroll or de-enroll coverage for a family member, you must complete Sections 1, 2, and 5. List only the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify LLNS of a change, subject to payroll deadlines. If you are changing plans, complete Sections 1 and 3 only; your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with state and federal law.

As a participant in LLNS-sponsored plans, you agree to the following terms and conditions:

1. Most of the medical plans that LLNS offers including the medical portion of Anthem Blue Cross PLUS, Anthem Blue Cross PPO and Anthem Blue Cross EPO (offered by Anthem Blue Cross of California®), Anthem Blue Cross CORE Value-CA, Anthem Blue Cross HDHP, Kaiser Permanente, Kaiser Permanente HDHP, and the DeltaCare USA dental plan ***require resolution of medical malpractice and other disputes through binding arbitration. When you enroll in these plans, you agree that any dispute between you (and/or your enrolled family members) and the medical or dental plan must be submitted to binding arbitration. You agree to waive your right to a jury or court trial to resolve these disputes.*** For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.
2. You acknowledge and accept all terms and conditions of the LLNS-sponsored plans in which you are enrolled as stated in the plan booklets.
3. If you enroll family members, LLNS and/or the carrier may require proof of eligibility. Marriage or birth certificates, adoption papers, tax records, and the like may be requested. You agree to provide such documentation upon request.
4. If you enroll your eligible registered domestic partner and/or your partner's eligible child(ren), or if you enroll or have enrolled your natural or adopted child who is not claimed as your tax dependent, you acknowledge that the LLNS/employer contribution for their medical and/or dental coverage may be considered your taxable income, subject, to FICA (Social Security and Medicare) and federal and California state income tax withholding.
5. If you specifically ask LLNS representatives to intercede on your behalf with your insurance plan, LLNS representatives will request minimum necessary health information required to assist you with your problem. If more protected health information is involved in solving your problem, in compliance with state privacy laws and federal laws, including HIPAA (Health Insurance Portability and Accountability Act of 1996), you may be required to sign an authorization allowing LLNS to provide the insurance plan with relevant personal health information or authorizing the insurance plan to release such information to the LLNS representative.
6. By making an election with your written or your electronic signature you are authorizing LLNS to take deductions from your earnings (employees) to cover your monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
7. Actions you take during Open Enrollment will be effective at the beginning of the following Plan Year unless otherwise stated.
8. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in plan documents and by the LLNS Benefits Office. You agree that you will de-enroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.
9. Making false statements about satisfying eligibility criteria, failing to notify LLNS of loss of eligibility within 31 days of such loss, or failing to provide documentation when requested will lead to de-enrollment of the family members and possible legal action. In addition, employees/retirees may be subject to disciplinary action (e.g., loss of health benefits for up to 12 months) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

CONTINUATION PRIVILEGES

For legal spouse, natural or adopted child, stepchild, legal ward, and/or other child

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued plan coverage for a certain period of time at monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, divorce, or are legally separated, or because a child ceases to be eligible. Call the Benefits Office for more information.

For registered domestic partner, partner's child and/or adult dependent relative*

While not required under COBRA, LLNS's health carriers have agreed to provide continuation coverage for an eligible registered domestic partner, and/or a partner's child, or an adult dependent relative enrolled by 12/31/03. Coverage may continue for a certain period of time at specified monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, because your relationship with an adult dependent relative or registered domestic partner ends, or because an adult dependent relative or a partner's child is no longer eligible for coverage. Call the Benefits Office for more information.

WHEN ELIGIBILITY ENDS

For registered domestic partner, partner's child, and/or adult dependent relative*

Unless continuation coverage is elected, LLNS-sponsored group insurance coverage stops at the end of the month the dependent is no longer eligible. **LLNS requires the employee to provide the registered domestic partner or the adult dependent relative with a copy of this cancellation form.** For medical, dental, or vision plan continuation coverage, the registered domestic partner or adult dependent relative should call the employee's Benefits Office.

* **NOTE: An adult dependent relative is eligible to continue LLNS-sponsored medical, dental, and/or vision coverage if enrolled by December 31, 2003, and coverage is continuous.** Your adult dependent relative must not be eligible for Medicare Part A.

DEPCARE PROVIDER AND COST CHANGE EVENTS			
Code	**COST CHANGE (does not apply if provider is your relative by blood or marriage)**		
D-1	there is an increase in provider's cost	D-2	there is a decrease in provider's cost
Code	**CHANGE IN PROVIDER OR COVERAGE**		
E-1	there is a change in provider	E-5	your spouse stops working
E-2	there is a reduction in hours of care, or cessation of care	E-6	you or your spouse changes work schedule and this creates, changes or eliminates need for care
E-3	there is a change (in whole or part) from paid to free care or vice versa	E-7	your spouse is not working or looking for work and becomes a full-time student or becomes incapable of self-care
E-4	your spouse starts working	E-8	your spouse is not working or looking for work and is no longer a full-time student or is no longer incapable of self-care

HIPAA (Health Insurance Portability and Accountability Act of 1996) Notification for Medical Program Eligibility

If you are declining enrollment for yourself or your eligible family members because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your eligible family members** in a LLNS-sponsored medical plan if you or your family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you or your family members). You must request enrollment within 31 days after your or your family member's other medical coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a newly eligible family member as a result of marriage/registered domestic partnership, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage/partnership, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Office.

Note: If you are enrolled in a LLNS medical plan, you may be able to change medical plans if:

- you acquire a newly eligible family member; or
- your eligible family member loses other coverage.

In either case, you must request enrollment within 31 days of the occurrence.

** **To be eligible for plan membership you and your family members must meet all LLNS eligibility requirements for coverage (please check with the LLNS Benefits Office for details.) All plan members are subject, as a condition of coverage, to eligibility verification audit by LLNS and/or insurance carriers.**

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires LLNS to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be transmitted to the federal and state governments when required by law.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011.6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.