SUPPLEMENTAL DISABILITY/LIFE/AD&D ENROLLMENT, CHANGE, CANCELLATION FORM

HEALTH AND WELFARE PLANS (rev. 11/2023)

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 (###) ###-####

2. EMPLOYEE ACTIONS

Instructions:

To increase coverage level for Supplemental Life and Supplemental Disability insurance, employees must fill out a Statement of Health form and submit the form to the prospective insurance carriers. Contact the Benefits Office to request the Statement of Health forms.

A Statement of Health is not required to decrease or cancel coverage.

Check all that apply.

CHANGE OR CANCEL COVERAGE

☐ Change or cancel coverage indicated below (date: _____)

COMMENTS:

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

(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)

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

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

(Check one):
☐ Basic Plan ($5,000 for each dependent)

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

☐ Dependent Life –Spouse/ Registered Domestic Partner Only
Amount: $_____*
(Increments of $10,000; maximum of $200,000

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

☐ 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	

EMPLOYEE'S SIGNATURE	DATE	SYSTEM UPDATED BY	DATE

SEE NEXT PAGE FOR PRIVACY NOTIFICATIONS

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

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

Use this form to enroll in, change, or cancel 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.

Current enrollments will remain in effect until you notify LLNS of a change, subject to payroll deadlines.

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.

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.