This form must be received by the Benefits Department within 31 calendar days of the mid-year election change event..

Press Tab to begin filling out the form.

UCI

SANDIA NATIONAL LABORATORIES

DENTAL & VISION CARE PLAN DISENROLLMENT FORM

Name (Last, First, Middle Initial)			Social Security Number
☐ Male ☐ Female	Date of Birth	Business Phone Number	Home Phone Number

Dependents to be disenrolled from:

☐ **Dental** ☐ **Vision**

					FOR BENEFITS USE ONLY	
Dependent(s) Name(s)	Relationship to Employee	Gender	Birth Date	Social Security #	Effective Date	Cancel Date

Reason for Dependent Disenrollment ______________________________

Effective Date ____________

For Benefits Use Only:

SNL Database Updated: ____________

______________________________ ____________
Employee Signature Date

Return this form to:
Sandia National Laboratories
Attn: Benefits Customer Service
PO Box 5800 MS 1022
Albuquerque, NM 87185