This form must be received by the Benefits Department within 31 calendar days of the mid-year election change event or hire date, whichever is applicable.

Press Tab to begin filling out the form.

SF 4400-ADV (6-2004)
Supersedes (2-2004) issue

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☐ **Initial Enrollment** ☐ **Reinstatement from LOA** ☐ **Additions/Changes**

Protect this form as sensitive when information is entered

APPLICATION FOR SANDIA'S DENTAL & VISION CARE PLAN

Name (Last, First, Middle Initial)			Social Security Number	Union
☐ Male ☐ Female	Date of Birth	Sandia Hire Date	Business Phone Number	Home Phone Number
Address		City	State	Zip Code

Type of Coverage: (Employee Coverage)

☐ **DENTAL**
- ☐ **Single**
- ☐ **Family***
- ☐ **Decline**
- ☐ **Dependent of another Sandian****

☐ **VISION**
- ☐ **Single**
- ☐ **Family***
- ☐ **Decline**
- ☐ **Dependent of another Sandian****

*If you checked Family, please list your dependents below.
**If you are a dependent under another Sandian's dental and/or vision plan(s), please list their name and social security number here: _____

Dependents to be Insured

Eligible Dependents are defined in the applicable Summary Plan Descriptions.

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

For Benefits Use Only:

SNL Database Updated: _____

Reason for enrollment (e.g., new hire, marriage, new baby, etc.) _____

Dental & Vision coverage effective date: _____

_____ _____
Employee Signature Date

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

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