



Enrollment/Change Forms

IMPORTANT INFORMATION CONCERNING YOUR MEDICAL/DENTAL/VISION FORMS

In accordance with your recent request, enclosed are forms to change your current participation in the medical, dental, and vision plans. Please complete all applicable information, sign, date, and return the forms to the applicable address noted above.

Please note the following important information.

Requests for participation changes that result from qualifying events such as marriage, birth, or adoption must be made **within 31 days of the event**. Changes received after the initial 31-day eligibility period cannot be accepted. This means that your new dependents cannot be added to your coverage until the next open enrollment period. If you are attempting to remove dependents from your existing contract and do not do so within the initial 31-day period, you may be subject to a pre-tax penalty.

If you are adding a new spouse, **a copy of the marriage certificate and spouse's social security card are required before the dependent can be added to your plan. A birth certificate, court order, or other evidence of dependency, as well as a social security card are required to add children.** For newborns, a copy of the birth certificate and social security card are required. We will, however, process eligibility for newborns pending receipt of the social security card. It must be presented within 61 days of the child's birth in order for coverage to be continued.

PLEASE NOTE – Changes to your medical, dental, and/or vision insurance cannot take effect until you return this enrollment form, **along with all required documentation** to Benefit Plans.

If you have any questions concerning the forms or dependent eligibility, please contact Benefits per the contact information below.

Benefits PO Box 30020 Amarillo, TX 79120-0020 Local: (806) 573-1100 Fax: (806) 573-6805 Email: BenefitsPantex@pantex.doe.gov

*Customer Service Representatives are available:
Monday through Thursday from 7:00 a.m. to 3:30 p.m. CST*



Enrollment/Change Forms

MEDICAL

ENROLL, ADD, CHANGE, OR CANCEL FORM

Phone: (806) 573-1100
Email: BenefitsPantex@pantex.doe.gov

INSURED'S NAME (First) (Middle Initial) (Last Name)			SOCIAL SECURITY NO. (Last Four)		BADGE	
STREET			CITY		STATE	ZIP CODE
PAYROLL ☐ PGU ☐ MTC ☐ EXEMPT ☐ NENB			EFFECTIVE DATE 1/1/27			
STATUS	☐ ACTIVE ☐ RETIRED ☐ SPOUSE OF RETIREE ☐ SPOUSE OF DECEASED RETIREE					
	☐ LONG TERM DISABILITY ☐ DISPLACED DEFENSE WORKER ☐ 3-MONTH CONTINUATION COBRA ☐ SPOUSE OF DECEASED EMPLOYEE					
	IF RETIRED, DO YOU HAVE 10 YEARS OF FULL- TIME COMPANY SERVICE? ☐ YES ☐ NO				IF THE INSURED IS A SPOUSE OF A RETIREE THAT IS OVER AGE 65, LIST RETIREE'S SSN NO.: (Last Four)	
COVERAGE TYPE ☐ CHOICE FUND HSA ☐ PPO CORE ☐ PPO SELECT			COVERAGE LEVEL ☐ INDIVIDUAL ☐ DUAL ☐ FAMILY			
			RETIREES I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY PENSION PAYMENT ☐ YES ☐ NO			
MEDICAL INSURANCE ENROLLMENT INFORMATION						
INSTRUCTIONS Complete this worksheet to enroll, add, or cancel a dependent from your medical insurance, or make changes to your dependents' personal information (Such as name spelling or date of birth). If you are adding or cancelling coverage on a dependent, you must indicate a reason at the bottom of this form.						
First Name	Last Name	Date of Birth	Sex	Relationship; Spouse, Son, Daughter, or Handicapped Child Over Age 26	Enroll, Add, Change or Cancel Coverage	
REASON FOR ADDING OR CANCELLING COVERAGE I understand that any additions to the medical plan must be added within 31 days of the qualifying event. If a dependent add request is received beyond 31 days but within 61 days, coverage is effective the first day of the month following the date the enrollment form is received. If this happens, you will experience up to a 3-month lapse in coverage. Otherwise, you will have to wait until Open Enrollment to enroll the dependent, and the coverage will not be effective until the next January 1.						
REASON FOR CHANGE	☐ MARRIAGE		DATE OF MARRIAGE		☐ BIRTH OR ADOPTION (A copy of the adoption papers signed by the court must be provided.) DATE OF BIRTH OR ADOPTION	
	☐ DIVORCE (A copy of the divorce decree signed by the court official must be provided.)		DATE OF DIVORCE		☐ DEPENDENT LOST ELIGIBILITY STATUS DATE OF EVENT	
	☐ CHANGE OF EMPLOYMENT STATUS (SELF OR SPOUSE)		DATE OF EVENT		☐ OTHER (EXPLAIN BELOW) DATE OF EVENT	
	OTHER CHANGE EXPLANATION: 2027 Open Enrollment					
SIGNATURE:				DATE:		

Acronyms: Metal Trades Council (MTC), Nonexempt/Nonbargaining (NENB), Pantex Guards Union (PGU), Preferred Provider Organization (PPO), Social Security Number (SSN)



Health Savings Account Contribution Change Form

NAME	SOCIAL SECURITY NUMBER (Last Four Only)
EFFECTIVE DATE	BADGE NUMBER

The contribution deducted from each pay period will be set up by Benefits based on how you complete this form. You cannot exceed the maximum annual contribution limits show below.

2027 MAXIMUM ANNUAL CONTRIBUTION PER INTERNAL REVENUE SERVICE (IRS): Employee only- \$4,500 | Family- \$9,000

Limits below are less the PanTeXas Deterrence, LLC (PXD) \$250 employee-only or \$500 family contributions. These funds count towards the maximum.

Basic Contribution

Employee-only..... \$4,250
 Employee +1 or more..... \$8,500

Catch-Up Contribution (Age 55 or older)

Employee-only..... \$1,000
 Employee +1 or more..... \$1,000

BASIC CONTRIBUTION CHANGE REQUESTS

- ☐ I wish to contribute or change a **pay period** amount of \$_____ to my Health Spending Account (HSA) on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise or reach my limit.
- ☐ I wish to make a single contribution of \$_____ to my HSA on a pre-tax basis. I understand this will be deducted from my paycheck one-time only for this year.
- ☐ I wish to **cancel** my pre-tax basis contributions to my HSA.

CATCH-UP CONTRIBUTION CHANGE REQUESTS

- ☐ I wish to contribute or change a **pay period** amount of \$_____ to my HSA on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise or reach my limit.
- ☐ I wish to make a single contribution of \$_____ to my HSA on a pre-tax basis. I understand this will be deducted from my paycheck one-time only for this year.
- ☐ I wish to **cancel** my pre-tax catch-up contributions to my HSA.

SIGNATURE	DATE 1/1/27
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EMPLOYEE AUTHORIZATION: I authorize PanTeXas Deterrence, LLC (PXD) to withhold from my pay contributions for the Health Savings Account (HSA) on a pre-tax basis. Should I fail to verify my deductible status or inaccurately disclose my status, it could impact my ability to make HSA contributions. I also understand changes are not retroactive and will not occur prior to the next payroll effective date.

Submit completed form via mail or email to Benefits:

Benefits PO Box 30020 Amarillo, TX 79120-0020 Local: (806) 573-1100 Fax: (806) 573-6805 Email: BenefitsPantex@pantex.doe.gov
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 Monday through Thursday from 7:00 a.m. to 3:30 p.m. CST*



Flexible Spending Accounts

NAME		SOCIAL SECURITY NUMBER (Last Four Only)	
EFFECTIVE DATE 1/1/27		BADGE NUMBER	
REASON FOR CHANGE			
☐ NEW HIRE		☐ BIRTH/ADOPTION (A copy of the adoption papers signed by the court must be provided.)	
☐ MARRIAGE		☐ LOSS OF COVERAGE	
☐ DIVORCE (A copy of the official divorce decree signed by the court must be provided.)		☐ OPEN ENROLLMENT	
☐ OTHER	DATE OF EVENT 1/1/27	EXPLAIN 2027 Open Enrollment	

2026* Limit for Health Care Flexible Spending Account - \$3,400

Covers eligible health care expenses for you and your eligible dependents.

You may contribute from \$50 up to \$3,400 per year to a Health Care Flexible Spending Account (FSA).

*2027 IRS FSA limit not released at time of publishing.

☐ I elect to contribute a total annual amount to the Health Care FSA for 2027: \$ _____
☐ Waive ☐ Cancel

2026* Limit for Dependent Care Flexible Spending Account - \$7,500

Covers daycare and elder care for eligible dependents.

For single individuals and married couples filing jointly, you may contribute from \$50 up to \$7,500.

For married individuals filing separately, you may contribute from \$50 up to \$3,750.

*2027 IRS FSA limit not released at time of publishing.

☐ I elect to contribute a total annual amount to the Dependent Care FSA for 2027: \$ _____
☐ Waive ☐ Cancel

Eligible expenses can be found at <https://hsabank.com/HSABank/Learning-Center/IRS-qualified-medical-expenses>

SIGNATURE	DATE
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I authorize PanTeXas Deterrence, LLC (PXD) to make the above pretax deductions on a weekly or bi-weekly basis, as appropriate, to fund my 2027 Flexible Spending Account(s) for health care expenses and/or dependent care expenses. I certify that the Flex Spending Account debit card will only be used for eligible medical expenses for myself and my eligible dependents. I understand that I take any liability incurred if I submit ineligible expenses for reimbursement or if I fail to follow the regulations for the Flexible Spending Account(s). Only eligible expenses incurred on or after January 1, 2027 through March 15, 2028 are eligible for reimbursement from your 2027 FSA. If waiving plans - I understand that I am eligible to participate in the Health Flexible Spending Account and/or Dependent Care Flexible Spending Account offered by PXD, LLC and have voluntarily decided not to enroll. I understand that I will not be entitled to enroll within the calendar year unless there is a qualifying event as referenced in the Summary Plan Description and that the change must be made within 31 days of the qualifying event and be consistent with the event.

**Submit completed
form via mail or
email to Benefits:**

Benefits
PO Box 30020
Amarillo, TX 79120-0020
Local: (806) 573-1100
Fax: (806) 573-6805
Email: BenefitsPantex@pantex.doe.gov

Customer Service Representatives are available:
Monday through Thursday from 7:00 a.m. to 3:30 p.m. CST



Enrollment/Change Forms

DENTAL

ENROLL, ADD, CHANGE, OR CANCEL FORM

Phone: (806) 573-1100
Email: BenefitsPantex@pantex.doe.gov

INSURED'S NAME (First) (Middle Initial) (Last Name)			SOCIAL SECURITY NO.: (Last Four)		BADGE	
STREET			CITY		STATE	ZIP CODE
PAYROLL ☐ PGU ☐ MTC ☐ EXEMPT ☐ NENB			EFFECTIVE DATE 1/1/27			
STATUS	☐ ACTIVE		☐ RETIRED		☐ SPOUSE OF RETIREE	
	☐ LONG TERM DISABILITY		☐ DISPLACED DEFENSE WORKER		☐ SPOUSE OF DECEASED RETIREE	
	☐ 3-MONTH CONTINUATION COBRA		☐ SPOUSE OF DECEASED EMPLOYEE			
	IF RETIRED, DO YOU HAVE 10 YEARS OF FULL-TIME COMPANY SERVICE?		COMPANY SERVICE DATE		IF THE INSURED IS A SPOUSE OF A RETIREE THAT IS OVER AGE 65, LIST RETIREE'S SSN NO.: (Last Four)	
☐ YES		☐ NO				
COVERAGE TYPE ☐ BASIC ☐ BUY-UP ☐ ENHANCED			COVERAGE LEVEL ☐ INDIVIDUAL ☐ DUAL ☐ FAMILY			
			RETIREES I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY PENSION PAYMENT ☐ YES ☐ NO			
DENTAL INSURANCE ENROLLMENT INFORMATION						
INSTRUCTIONS Complete this worksheet to enroll, add, or cancel a dependent from your dental insurance, or make changes to your dependents' personal information (Such as name spelling or date of birth). If you are adding or cancelling coverage on a dependent, you must indicate a reason at the bottom of this form.						
First Name	Last Name	Date of Birth	Sex	Relationship; Spouse, Son, Daughter, or Handicapped Child Over Age 26		Enroll, Add, Change or Cancel Coverage
REASON FOR ADDING OR CANCELLING COVERAGE I understand that any additions to the dental plan must be added within 31 days of the qualifying event. If a dependent add request is received beyond 31 days but within 61 days, coverage is effective the first day of the month following the date the enrollment form is received. If this happens, you will experience up to a 3-month lapse in coverage. Otherwise, you will have to wait until Open Enrollment to enroll the dependent, and the coverage will not be effective until the next January 1.						
REASON FOR CHANGE	☐ MARRIAGE		DATE OF MARRIAGE		☐ BIRTH OR ADOPTION (A copy of the adoption papers signed by the court must be provided.)	
	☐ DIVORCE (A copy of the divorce decree signed by the court official must be provided.)		DATE OF DIVORCE		☐ DEPENDENT LOST ELIGIBILITY STATUS	
	☐ CHANGE OF EMPLOYMENT STATUS (SELF OR SPOUSE)		DATE OF EVENT		☐ OTHER (EXPLAIN BELOW)	
	OTHER CHANGE EXPLANATION: 2027 Open Enrollment					
SIGNATURE:			DATE:			

Acronyms: Metal Trades Council (MTC), Nonexempt/Nonbargaining (NENB), Pantex Guards Union (PGU), Social Security Number (SSN)



Enrollment/Change Forms

VISION

ENROLL, ADD, CHANGE, OR CANCEL FORM

Phone: (806) 573-1100
Email: BenefitsPantex@pantex.doe.gov

INSURED'S NAME (First) (Middle Initial) (Last Name)			SOCIAL SECURITY NO.: (Last Four)		BADGE		
STREET			CITY		STATE	ZIP CODE	
PAYROLL ☐ PGU ☐ MTC ☐ EXEMPT ☐ NENB			EFFECTIVE DATE 1/1/27				
STATUS	☐ ACTIVE		☐ RETIRED		☐ SPOUSE OF RETIREE		
	☐ LONG TERM DISABILITY		☐ DISPLACED DEFENSE WORKER		☐ SPOUSE OF DECEASED RETIREE		
	☐ 3-MONTH CONTINUATION COBRA		☐ SPOUSE OF DECEASED EMPLOYEE				
	IF RETIRED, DO YOU HAVE 10 YEARS OF FULL- TIME COMPANY SERVICE?		IF THE INSURED IS A SPOUSE OF A RETIREE THAT IS OVER AGE 65, LIST RETIREE'S SSN NO.: (Last Four)				
☐ YES		☐ NO					
COVERAGE TYPE ☐ BASIC ☐ ALTERNATIVE/BUY-UP			COVERAGE LEVEL ☐ INDIVIDUAL ☐ DUAL ☐ FAMILY				
			RETIREES I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY PENSION PAYMENT ☐ YES ☐ NO				
VISION INSURANCE ENROLLMENT INFORMATION							
INSTRUCTIONS Complete this worksheet to enroll, add, or cancel a dependent from your vision insurance, or make changes to your dependents' personal information (Such as name spelling or date of birth). If you are adding or cancelling coverage on a dependent, you must indicate a reason at the bottom of this form.							
First Name	Last Name	Date of Birth	Sex	Relationship; Spouse, Son, Daughter, or Handicapped Child Over Age 26		Enroll, Add, Change or Cancel Coverage	
REASON FOR ADDING OR CANCELLING COVERAGE I understand that any additions to the vision plan must be added within 31 days of the qualifying event. If a dependent add request is received beyond 31 days but within 61 days, coverage is effective the first day of the month following the date the enrollment form is received. If this happens, you will experience up to a 3- month lapse in coverage. Otherwise, you will have to wait until Open Enrollment to enroll the dependent, and the coverage will not be effective until the next January 1.							
REASON FOR CHANGE	☐ MARRIAGE		DATE OF MARRIAGE		☐ BIRTH OR ADOPTION	(A copy of the adoption papers signed by the court must be provided.) DATE OF BIRTH OR ADOPTION	
	☐ DIVORCE		(A copy of the divorce decree signed by the court official must be provided.) DATE OF DIVORCE		☐ DEPENDENT LOST ELIGIBILITY STATUS	DATE OF EVENT	
	☐ CHANGE OF EMPLOYMENT STATUS (SELF OR SPOUSE)		DATE OF EVENT		☐ OTHER (EXPLAIN BELOW)	DATE OF EVENT	
	OTHER CHANGE EXPLANATION: 2027 Open Enrollment						
SIGNATURE:				DATE:			

Acronyms: Metal Trades Council (MTC), Nonexempt/Nonbargaining (NENB), Pantex Guards Union (PGU), Social Security Number (SSN)



Enrollment/Change Forms

VOLUNTARY PLANS

NAME		SOCIAL SECURITY NUMBER (Last Four Only)	
EFFECTIVE DATE 1/1/27		BADGE NUMBER	
REASON FOR CHANGE			
☐ NEW HIRE		☐ BIRTH/ADOPTION (A copy of the adoption papers signed by the court must be provided.)	
☐ MARRIAGE		☐ LOSS OF COVERAGE	
☐ DIVORCE (A copy of the official divorce decree signed by the court must be provided.)		☐ OPEN ENROLLMENT	
☐ OTHER	DATE OF EVENT 01/01/2027	EXPLAIN 2027 Open Enrollment	

Coverage Type

Accident	Cancer	Critical Illness	Hospital Indemnity	Legal
☐ High	☐ \$15,000	☐ \$10,000	☐ High	☐ Legal
☐ Low	☐ \$30,000	☐ \$15,000	☐ Low	☐ Legal Plus Parents
		☐ \$30,000		

Complete the below if you wish to enroll/change a dependent in a voluntary benefit plan.

First Name	Last Name	DOB	Sex	SSN (Last Four)	Accident	Cancer	Critical Illness	Hospital Indemnity

I understand that these deductions will be made on a post-tax basis from my wages.

SIGNATURE	DATE
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The company expects and intends to continue the plans in your benefits program but reserves its right to terminate each of the plans, in whole or in part, without notice. The company also serves its right to amend each of the plans at any time.