

For Employer Use: PAYROLL DEDUCTIONS \$  MEDICAL \$  DENTAL \$  VISION \$  DISABILITY \$  ADDITIONAL LIFE \$  Former Employer (if covered under NMPSIA) Basic Life Eff. Date (mm/dd/yyyy) Other Cvrge Eff. Date (mm/dd/yyyy)



**New Mexico Public Schools Insurance Authority**  
**EMPLOYEE ENROLLMENT APPLICATION**

District/Entity Name **New Mexico Tech** District/Entity # **108**

Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943

**1** Social Security Number \_\_\_\_\_ Name (Last, First, Middle) \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Marital Status  S  M Gender  F  M Preferred E-Mail Address \_\_\_\_\_ By furnishing my e-mail address on this form, I am consenting to receive communications related to my participation in NMPSIA's benefit program by e-mail.  Check this box if you do not wish to receive plan communications by e-mail. Work Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

**2** ENROLLMENT STATUS  Employee Only  2-Party (Employee + Spouse or Child)  Family (Employee + 2 or more)

**3** ENROLLMENT Elect your coverage offered by your employer

BASIC LIFE \$50,000: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form)  Decline Basic Life

MEDICAL:  Blue Cross Blue Shield of NM  Cigna  Presbyterian  Decline Medical. Reason for declining coverage: \_\_\_\_\_  
 High Option Plan (Default)  High Option Plan (Default)  High Option Plan (Default) \_\_\_\_\_  
 Low Option Plan  Low Option Plan  Low Option Plan  
 EPO Option Plan Are you eligible for Medicaid?  Yes  No

DENTAL: Delta Dental  United Concordia  Decline Dental  
 High Option Plan (Default)  Low Option Plan  High Option Plan (Default)  Low Option Plan

VISION: Davis Vision (2 year enrollment required)  Decline Vision

LONG TERM DISABILITY: The Standard 90 Day BWP  Decline Long Term Disability

ADDITIONAL LIFE: The Standard (Complete Schedule A Beneficiary Form) Select:  1X Base Annual Salary  Spouse Life  Child Life Employee must enroll in Additional Life to add Spouse and/or Child Life  Decline Employee Additional Life  Decline Dependent Life

**4** DEPENDENT INFORMATION List all dependents you wish to enroll. Indicate an A (add) or N/A (not applicable) for all names listed below. Please provide requested information for additional dependents on separate sheet if necessary.

Med	Dntl	Visn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, or Court Order Attached
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No

**5** EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that services will be available subject to the exclusions, limitations and the conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined this application and supporting documentation, and to the best of my knowledge and belief, they are true, correct, and complete. **Read reverse side before signing.**

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR DATE OF HIRE**

**6** EMPLOYER CERTIFICATION **ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY EMPLOYER.**

I attest that to the best of my knowledge that this applicant is an employee of my district/entity (or meets the one-bus owner definition) and works the minimum number of hours per week required for NMPSIA benefits.

Date of Hire	Base Annual Salary \$	# of hours worked weekly	Job Title	<input type="checkbox"/> Check <b>only</b> if Variable Hour Employee	List date Variable Hour Employee became eligible for <b>medical only</b> coverage	Date Received in Your Office
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BENEFITS SPECIALIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

## SCHEDULE A – BENEFICIARY ASSIGNMENT NM TECH

Employee Social Security Number	Employee Name	School District/Employer
Mailing Address:		Date of Birth (in mm/dd/yyyy format)

### Primary Beneficiary:

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

### Secondary Beneficiary (in the event the primary beneficiary is not living at the time of the insured's death):

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

### STATEMENT OF MARITAL STATUS (check one)

- I AM NOT MARRIED. I understand that if I marry, it will affect my right to dispose of community property, and that I should then review my beneficiary designation.
- I AM MARRIED. My spouse is the Primary Beneficiary and/or is designated to receive 50% or more of my benefit.
- I AM MARRIED. My spouse is not the Primary Beneficiary and/or is designated to receive less than 50% of my benefit.

EMPLOYEE SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

Witnessed by Employer: \_\_\_\_\_

DATE: \_\_\_\_\_

**IMPORTANT NOTE:** Community Property Laws are applicable to employees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin; therefore, a spouse has property interest in insurance provided to the employee through his/her employment.

**RETURN TO YOUR EMPLOYER'S BENEFIT OFFICE**