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 Cvg Eff. Date (mm/dd/yyyy)
	$	$	$	$	$			

New Mexico Public Schools Insurance Authority

EMPLOYEE ENROLLMENT / CHANGE FORM

This form is Effective 1/1/2025.

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

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

RESET FORM

1 Social Security Number	Name (Last, First, Middle)	Date of Birth

Mailing Address	City	State	Zip Code	Home Phone Number

Marital Status	Gender	E-Mail Address Mandatory (Do not block emails from **no-reply@easipta.com**)	Work Phone Number	Cell Phone Number
☐ S ☐ M	☐ F ☐ M			

REASON FOR CHANGE (Answer questions below):

What event took place?

What date did event take place?

☐ New Hire (enrolling within 31 days of hire) ☐ Evidence of Insurability

☐ Qualifying Event (enrolling within 31 days of event)

2 ENROLLMENT

What is your current enrollment status? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

What enrollment status are you requesting? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

Check One : ☐ **ADD COVERAGE / DEPENDENTS** ☐ **CANCEL COVERAGE / DEPENDENTS**

BASIC LIFE: The Standard **$50,000** ☐ **Decline Free Basic Life**

MEDICAL:

☐ **Blue Cross Blue Shield of NM**
- ☐ High Option (*Default*)
- ☐ Low Option
- ☐

☐ **Presbyterian (*Default*)**
- ☐ High Option (*Default*)
- ☐ Low Option

☐ Decline Medical

Reason: _____

Eligible for Medicaid? ☐ Yes ☐ No

DENTAL: ☐ **Blue Cross Blue Shield of NM Dental (Default)** ☐ High Option ☐ Low Option ☐ **United Concordia** ☐ High Option ☐ Low Option ☐ **Delta Dental** ☐ High Option ☐ Low Option ☐ Decline Dental

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

☐ **LONG TERM DISABILITY**: **The Standard 90 Day BWP** (New Hire, Qualifying Event, or Evidence of Insurability) ☐ Decline Long Term Disability

☐ **ADDITIONAL LIFE**: **The Standard** (New Hire, Qualifying Event, or Evidence of Insurability) **Select:** ☐ 1X Employee Base Annual Salary ☐ Spouse Life ☐ Child Life ☐ Decline Employee Additional Life ☐ Decline Dependent Life ☐ Decline Child Life

3 DEPENDENT INFORMATION

List all dependents you wish to enroll. Provide requested information for additional dependents on separate form.
Indicate an A (add), D (drop), C (continue coverage), or N/A (not applicable) for all names listed below.

Med	Dntl	Visn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number **(REQUIRED)**	Date of Birth (mm/dd/yyyy) **(REQUIRED)**	Gender **(REQUIRED)**	Dependent's Relationship to You **(REQUIRED)**	Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached **(REQUIRED)**
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No

4 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.**

RETURN THIS FORM TO YOUR EMPLOYER BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR EVENT

EMPLOYEE SIGNATURE _____ DATE _____

5 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	☐ Check ***only*** if Variable Hour Employee	Date Variable Hour Employee became eligible for **medical only** coverage	Date Received in Your Office
	$					

EMPLOYER BENEFITS SPECIALIST SIGNATURE: **DATE:**