

For Employer Use: 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)			
PAYROLL DEDUCTIONS \$ \$ \$ \$ \$									District/Entity Name		District/Entity #	
					New Mexico Public Schools Insurance Authority				New Mexico Tech		108	
EMPLOYEE ENROLLMENT / CHANGE FORM												
This form is Effective 1/1/2026.												
Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943												
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?								☐ New Hire (enrolling within 31 days of hire)		☐ Evidence of Insurability		
What date did event take place?								☐ 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				☐ Presbyterian (Default)				☐ Decline Medical				
☐ High Option (Default)				☐ High Option (Default)				Reason: _____				
☐ Low Option				☐ Low Option				Eligible for Medicaid? ☐ Yes ☐ No				
☐												
DENTAL: ☐ Blue Cross Blue Shield of NM Dental (Default)				☐ United Concordia		☐ Delta Dental		☐ Decline Dental				
☐ High Option ☐ Low Option				☐ High Option ☐ Low Option		☐ High Option ☐ Low Option						
☐ 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				Select: ☐ 1X Employee Base Annual Salary				☐ Decline Employee Additional Life				
(New Hire, Qualifying Event, or Evidence of Insurability)				☐ Spouse Life ☐ Child 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:				