



New Mexico Public Schools Insurance Authority



RETIREE CHANGE CARD

FOR NEW MEXICO TECH (District ID 407)

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

Effective Date
(mm/dd/yyyy)

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

| | | | | |
|------------------------|-------------|--------------|-----------------|--------------------------|
| Mailing Address | City | State | Zip Code | Home Phone Number |
|------------------------|-------------|--------------|-----------------|--------------------------|

| | | | |
|--|---|---|--------------------------|
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | Gender <input type="checkbox"/> Female <input type="checkbox"/> Male | 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. <input type="checkbox"/> Check this box only if you do NOT wish to receive plan communications by e-mail. | Cell Phone Number |
|--|---|---|--------------------------|

| | |
|---|--|
| REASON FOR CHANGE: <input type="checkbox"/> New address and/or phone number <input type="checkbox"/> Switch Enrollment | Answer questions below What event took place? What date did event take place? |
|---|--|

2 ENROLLMENT

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

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

Check One: **ADD COVERAGE** **CANCEL COVERAGE** **SWITCH ENROLLMENT**

MEDICAL

Blue Cross Blue Shield of NM Cigna Presbyterian Decline Medical

High Option (Default) High Option Plan (Default) High Option (Default) Reason: _____

Low Option Low Option Plan Low Option Eligible for Medicaid? Yes No

EPO Option

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

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

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

| Med | Dntl | Visn | 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, Loss of Coverage, 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 |

4 RETIREE AUTHORIZATION STATEMENT

I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that benefits 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 me and my dependents.

Under penalties of perjury and insurance fraud, I declare that I have examined this application and to the best of my knowledge and belief, they are true, correct, and complete.

RETIREE SIGNATURE _____ DATE _____

5 NEW MEXICO TECH CERTIFICATION **FORM MUST BE SIGNED BY NEW MEXICO TECH.**

| | | | | |
|--|---|--------------------------------------|---|---|
| Retirement Date (mm/dd/yyyy) | Date of Termination of Active Coverage (mm/dd/yyyy) | Benefits Specialist Signature | Date Signed by Benefits Specialist (mm/dd/yyyy) | Date Received in Your Office (mm/dd/yyyy) |
|--|---|--------------------------------------|---|---|

Please read the NMPSIA Program Guide (provided to you by your benefits office) as you complete this form.

NMPSIA's Program Guide outlines the NMPSIA Eligibility Rules and administrative guidelines for enrollment. If you do not have this Guide, you can obtain a copy from your benefits office or at <https://nmpsia.com>.

ELIGIBILITY

The effective date for all your other lines of coverage is determined NM Tech. This effective date can never be made retroactive (prior to the date you officially apply).

ENROLLMENT

You may only apply for the lines of NMPSIA coverage offered by NM Tech.

Please keep the following in mind:

- You may enroll as single only for any line of NMPSIA coverage.

Indicate the status (*retiree only, two-party, or family*) for each line of coverage.

If both you and your spouse have coverage with NM Tech or under another NMPSIA affiliated employer, you and your spouse cannot double insure each other and your dependents under the NMPSIA Group Plan for any line of NMPSIA coverage.

Coverage for your dependents will begin on your effective date of coverage.

Medical and Prescription Drug Coverage – If you enroll in the medical plan, you are automatically enrolled in the Prescription Drug Program. You will receive a separate ID card from the NMPSIA Prescription Drug Manager to purchase your prescription drugs.

CONFIRMATION OF ENROLLMENT

Once your enrollment has been processed, the NMPSIA Eligibility Administrative Office will email you or mail you a Confirmation of Enrollment Notice to your *home (and to NM Tech)*. Please review this confirmation notice carefully and report any discrepancies to your Employee Benefits Office or to the NMPSIA Eligibility Administrative Office at 1 (800) 233-3164.

If you do not provide NM Tech with all of the appropriate documentation necessary to finalize your enrollment request, you will be contacted for the appropriate documentation. Please be sure to adhere to all deadlines associated with this request.