New Mexico Public Schools Insurance Authority

RETIREE ENROLLMENT APPLICATION

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** (mm/dd/yyyy)
Mailing Address		**City**	**State**	**Zip Code**	**Home Phone Number**

Marital Status	**Gender**	**Preferred E-Mail Address**	**Cell Phone Number**
☐ Single ☐ Married	☐ Female ☐ Male	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.	

2 ENROLLMENT STATUS ☐ Retiree Only ☐ 2-Party (Retiree + Spouse or Child) ☐ Family (Retiree + 2 or more)

3 ENROLLMENT **Elect your coverage offered by New Mexico Tech**

MEDICAL:

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

☐ **Cigna**
- ☐ High Option Plan *(Default)*
- ☐ Low Option Plan

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

☐ Decline Medical

Reason: _____

Eligible for Medicaid? ☐ Yes ☐ No

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

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	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
						☐ F ☐ M		☐ Yes ☐ No
						☐ F ☐ M		☐ Yes ☐ No
						☐ F ☐ M		☐ Yes ☐ No
						☐ F ☐ M		☐ Yes ☐ No

5 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 _____

6 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)