			Effective Date (mm/dd/yyyy)

New Mexico Public Schools Insurance Authority

NM TECH RETIREE ENROLLMENT / CHANGE FORM

District/Entity Name	District/Entity #
New Mexico Tech Retirees	407

This form is Effective 1/1/2025.

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

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**)		Cell Phone Number
☐ S ☐ M	☐ F ☐ M			

REASON FOR CHANGE (Answer questions below):

What event took place? ☐ New Retiree (enrolling within 31 days of retiring) ☐ 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?	☐ Retiree Only	☐ 2-Party(Retiree+Spouse/Child)	☐ Family (Retiree + 2 or more)
What enrollment status are you requesting?	☐ Retiree Only	☐ 2-Party(Retiree+Spouse/Child)	☐ Family (Retiree + 2 or more)

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

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

☐ **Retiree ADDITIONAL LIFE**: **The Standard $10,000** (New Retiree, Qualifying Event, or Evidence of Insurability) ☐ Decline Employee Additional 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		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 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, statements are true, correct, and complete.** Read reverse side before signing.

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

RETIREE SIGNATURE _____ DATE _____

5 NEW MEXICO TECH CERTIFICATION

ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY NM TECH.

I attest that to the best of my knowledge that this applicant is a retiree of New Mexico Tech and meets the eligibility requirements for NMPSIA benefits.

Date of Retirement (mm/dd/yyy)			Date of Termination of Active Coverage (mm/dd/yyyy)		Date Received in Your Office

NM TECH BENEFITS SPECIALIST SIGNATURE: **DATE:**