IMPORTANT HEALTH, DENTAL AND VISION INSURANCE INFORMATION

Regular, regular limited term, and full time temporary employees are eligible to participate in the New Mexico Tech health, dental, and vision plans. New Mexico Tech pays the larger portion of the premiums and the employee pays a portion – those amounts are explained in the NMPSIA information packet. In order to obtain coverage, the employee must select the plan(s) most beneficial for him/her and must complete the enrollment form in the packet as soon as possible but not later than 31 days after starting work.

Deductions for premiums will be made as soon after the employee enrolls as possible. NMPSIA health insurance requires that premiums be paid in advance of the start of coverage. In some cases, depending on the employee start date, double deductions must be made for one pay period in order to have health coverage at the start of the following month.

Example #1: A new employee begins working on March 15th and completes the NMPSIA enrollment that week. A double deduction will be made for health insurance at the next pay period in order to begin coverage on April 1st.

Example #2: A new employee begins working on March 15th and completes the NMPSIA enrollment towards the end of the month. Deductions for health insurance will be made in April at both pay periods but coverage will not begin until May 1st.

Please keep these examples in mind when deciding when to enroll in the health, dental and vision plans. Likewise, if you terminate employment at New Mexico Tech, your health, dental, and vision insurance will terminate at the end of the month in which you terminate regardless of the effective date.

EMPLOYEE SIGNATURE_____ DATE_____

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 Cvrg Eff. Date (mm/dd/yyyy)

New Mexico Public Schools Insurance Authority

New Mexico Public Schools Insurance Authority

EMPLOYEE ENROLLMENT APPLICATION

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

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

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 ☐ S ☐ M | **Gender** ☐ F ☐ M | **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. ☐ Check this box if you do not wish to receive plan communications by e-mail. | **Work Phone Number** | **Cell Phone Number**

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

3 **ENROLLMENT** **Elect your coverage offered by your employer**

☐ **BASIC LIFE $50,000**: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form) ☐ Decline Basic Life

MEDICAL: ☐ Decline Medical. Reason for declining coverage: _____

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

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

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

Are you eligible for Medicaid? ☐ Yes ☐ No

☐ **DENTAL: Delta Dental** ☐ High Option Plan *(Default)* ☐ Low Option Plan

☐ **United Concordia** ☐ High Option Plan *(Default)* ☐ Low Option Plan

☐ Decline Dental

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

☐ **LONG TERM DISABILITY: The Standard 90 Day BWP** ☐ Decline Long Term Disability

☐ **ADDITIONAL LIFE: The Standard** *(Complete Schedule A Beneficiary Form)* **Select:** ☐ 1X Base Annual Salary ☐ Spouse Life ☐ Child Life

Employee must enroll in Additional Life to add Spouse and/or Child Life

☐ Decline Employee Additional Life ☐ Decline Dependent Life

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	Add'l Life	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 **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**.

EMPLOYEE SIGNATURE _____ DATE _____

RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR DATE OF HIRE

6 **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	List date Variable Hour Employee became eligible for **medical only** coverage	Date Received in Your Office
	$					

BENEFITS SPECIALIST SIGNATURE **DATE**

New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

SCHEDULE A – BENEFICIARY ASSIGNMENT NM TECH

Employee Social Security Number	Employee Name	School District/Employer New Mexico Tech - 108
Mailing Address:		Date of Birth (in mm/dd/yyyy format)

Primary Beneficiary:

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Secondary Beneficiary **(in the event the primary beneficiary is not living at the time of the insured's death):**

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

STATEMENT OF MARITAL STATUS (check one)

☐ I AM NOT MARRIED. I understand that if I marry, it will affect my right to dispose of community property, and that I should then review my beneficiary designation.

☐ I AM MARRIED. My spouse is the Primary Beneficiary and/or is designated to receive 50% or more of my benefit.

☐ I AM MARRIED. My spouse is not the Primary Beneficiary and/or is designated to receive less than 50% of my benefit.

EMPLOYEE SIGNATURE _____ **DATE:** _____

Witnessed by Employer: _____ **DATE:** _____

IMPORTANT NOTE: Community Property Laws are applicable to employees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin; therefore, a spouse has property interest in insurance provided to the employee through his/her employment.

RETURN TO YOUR EMPLOYER'S BENEFIT OFFICE