Human Resources
(575) 835-5643 Phone
(575) 835-6963 fax

Insurance Continuation Notice

As a retiree of New Mexico Tech, you are eligible to continue your medical, dental and vision coverage.

Retiree coverage may be carried by the retiree or by their surviving spouse and dependents. The monthly cost for retiree coverage will depend on whether you elect Retiree only, 2-Party or Family coverage and also if you are eligible for Medicare.

Please indicate below whether or not you wish to continue your medical, dental and vision coverage.

Yes _____ No_____

If yes, Elect Plan:

Enrollment Status____Retiree Only ____2-Party (Retiree + Spouse or Child) ____Family (Retiree + 2 or more)

_____ _____
Signature Date

***Payment for this coverage must be made through either checking or savings account automatic payment. Non-payment will result in termination of coverage. Please fill out the attached authorization form for this deduction.

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Retiree Life Insurance Election

As a retiree of New Mexico Tech, you are eligible to continue a $10,000 life insurance policy. This policy will cost $1.16 per month.

Please indicate below whether or not you wish to purchase this life insurance.

_____ Yes, I would like to purchase $10,000 of life insurance.

_____ No, I do not wish to purchase $10,000 of life insurance.

_____ _____
Signature Date

**The payment for this coverage must be made through either checking or savings account automatic payment. Non-payment will result in termination of coverage. Please fill out the attached authorization form for this deduction.

NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

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Phone (575) 835-6963
Fax

Name_____ **Banner ID#**_____

Address_____

Email Address_____**Marital Status** _____**Date of Birth**_____

Insurance Coverage

Medical

☐ Blue Cross Blue Shield of New Mexico
- ☐ High Option Plan
- ☐ Low Option Plan
- ☐ EPO Option Plan

☐ Presbyterian
- ☐ High Option Plan
- ☐ Low Option Plan

Are you eligible for Medicare ☐ Yes ☐ No

Dental: Delta Dental

☐ High Option ☐ Low Option Plan ☐ Decline Dental

Dental: United Concordia

☐ High Option Plan ☐ Low Option Plan ☐ Decline Dental

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

Life - Retiree Only $10,000 ☐ Yes ☐ No

_____ _____ _____
Spouse Date of Birth Social Security #

Dependent Children

_____ _____ _____
Name Date of Birth Social Security #

_____ _____ _____
Name Date of Birth Social Security #

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Authorization Agreement for Automated Payments

I (we) hereby authorize New Mexico Institute of Mining and Technology to initiate debit entries to my/our _____Checking or _____Savings account indicated below and the depository name below, hereinafter called Depository, to debit same to such account.

Depository Information

Name: _____
Name of Financial Institution

City: _____ State: _____ Zip Code: _____

Routing #_____ Account # _____

This authority is to remain in full force and effect until New Mexico Institute of Mining and Technology and Depository has received written notification from me (or either of us) of its termination in such time and in such manner as to afford New Mexico Institute of Mining and Technology and Depository a reasonable opportunity to act on it.

Account Name: _____

Account Name: _____

Signature: _____ Date: _____

Please attach a voided check/bank form confirming routing/account number if you designate a checking account or a copy of a withdrawal slip/card if you designate a savings account.
***Payment for this coverage must be made through either checking or savings account automatic payment. Non-payment will result in termination of coverage.

			Effective Date (mm/dd/yyyy)

New Mexico Public Schools Insurance Authority
NM TECH RETIREE ENROLLMENT / CHANGE FORM

This form is Effective 1/1/2025.

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

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

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
- ☐ EPO 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:**

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 RETIREE

Retiree Social Security Number	Retiree Name	School District/Entity New Mexico Tech Retirees - 407
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 Retiree	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 Retiree	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.

RETIREE SIGNATURE _____ **DATE:** _____

Witnessed by NM Tech: _____ **DATE:** _____

IMPORTANT NOTE: Community Property Laws are applicable to retirees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin; therefore, a spouse has property interest in insurance provided to the retiree through New Mexico Tech.

RETURN TO NEW MEXICO TECH'S BENEFIT OFFICE