



Name _____ Banner ID# _____

Address _____

Sex _____ Marital Status _____ Date of Birth _____

ENROLLMENT STATUS

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

MEDICAL

☐ Blue Cross Blue Shield of New Mexico
☐ High Option Plan (Default)
☐ Low Option Plan

☐ Decline Medical
☐ Presbyterian
☐ High Option Plan (Default)
☐ Low Option Plan

DENTAL: ☐ Blue Cross Blue Shield ☐ Delta Dental

☐ High Option Plan (Default) ☐ Low Option Plan

☐ United Concordia

☐ Decline Dental

VISION: Davis Vision (2 year enrollment required)

☐ Yes ☐ No

LIFE

Retiree Life-Employee

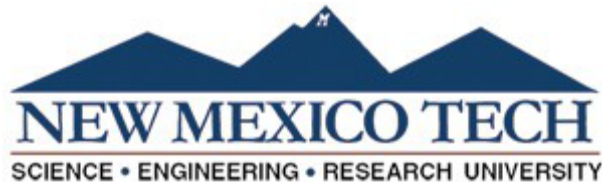
☐ Yes ☐ No

Spouse

Dependent Children

Name

Name



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 ☐

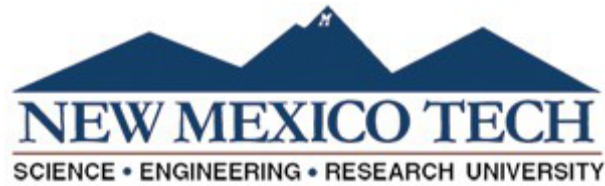
If yes, Elect Plan:

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.



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

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.

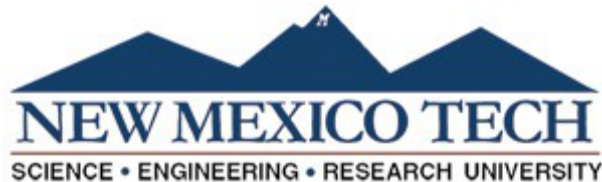
☐ Yes, I would like to purchase \$10,000 of life insurance.

☐ 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.



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

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								District/Entity Name New Mexico Tech Retirees				District/Entity # 407																																																	
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																																																																	
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 <u>Mandatory</u> (Do not block emails from no-reply@easipta.com)										Cell Phone Number																																																			
<input type="checkbox"/> S <input type="checkbox"/> M		<input type="checkbox"/> F <input type="checkbox"/> M																																																															
REASON FOR CHANGE (Answer questions below):																																																																	
What event took place?								<input type="checkbox"/> New Retiree (enrolling within <u>31 days</u> of retiring)				<input type="checkbox"/> Evidence of Insurability																																																					
What date did event take place?								<input type="checkbox"/> Qualifying Event (enrolling within <u>31 days</u> of event)																																																									
2 ENROLLMENT																																																																	
What is your current enrollment status?				<input type="checkbox"/> Retiree Only				<input type="checkbox"/> 2-Party(Retiree+Spouse/Child)				<input type="checkbox"/> Family (Retiree + 2 or more)																																																					
What enrollment status are you requesting?				<input type="checkbox"/> Retiree Only				<input type="checkbox"/> 2-Party(Retiree+Spouse/Child)				<input type="checkbox"/> Family (Retiree + 2 or more)																																																					
Check One: <input type="checkbox"/> ADD COVERAGE / DEPENDENTS <input type="checkbox"/> CANCEL COVERAGE / DEPENDENTS																																																																	
MEDICAL:																																																																	
<input type="checkbox"/> Blue Cross Blue Shield of NM				<input type="checkbox"/> Presbyterian (Default)				<input type="checkbox"/> Decline Medical																																																									
<input type="checkbox"/> High Option (Default)				<input type="checkbox"/> High Option (Default)				Reason: _____																																																									
<input type="checkbox"/> Low Option				<input type="checkbox"/> Low Option				Eligible for Medicaid?				<input type="checkbox"/> Yes <input type="checkbox"/> No																																																					
<input type="checkbox"/>																																																																	
DENTAL: <input type="checkbox"/> Blue Cross Blue Shield of NM Dental (Default) <input type="checkbox"/> United Concordia <input type="checkbox"/> Delta Dental <input type="checkbox"/> Decline Dental																																																																	
<input type="checkbox"/> High Option <input type="checkbox"/> Low Option				<input type="checkbox"/> High Option <input type="checkbox"/> Low Option				<input type="checkbox"/> High Option <input type="checkbox"/> Low Option																																																									
<input type="checkbox"/> VISION: Davis Vision (2 year enrollment required) <input type="checkbox"/> Decline Vision																																																																	
<input type="checkbox"/> Retiree ADDITIONAL LIFE: The Standard \$10,000 <input type="checkbox"/> Decline Employee Additional Life																																																																	
(New Retiree, Qualifying Event, or Evidence of Insurability)																																																																	
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.																																																																	
<table><tr><td>Med</td><td>Dntl</td><td>Visn</td><td></td><td>Dependent's Name (Last, First, Middle)</td><td>Social Security Number (REQUIRED)</td><td>Date of Birth (mm/dd/yyyy) (REQUIRED)</td><td>Gender (REQUIRED)</td><td>Dependent's Relationship to You (REQUIRED)</td><td>Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached (REQUIRED)</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td><input type="checkbox"/> F <input type="checkbox"/> M</td><td></td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td><input type="checkbox"/> F <input type="checkbox"/> M</td><td></td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td><input type="checkbox"/> F <input type="checkbox"/> M</td><td></td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td><input type="checkbox"/> F <input type="checkbox"/> M</td><td></td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr></table>																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)								<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
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)																																																								
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							<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, 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/yyyy)				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**

Blue Cross Blue Shield									
Single Premium									
Plan and Carrier	Medical	Single No Medicare Retiree Premium	Single No Medicare Employer Premium	Total Monthly Premium	Single with Medicare Retiree Premium	Single with Medicare Employer Premium	Total Monthly Premium		
High Option Plan		\$557.99	\$557.99	\$1,115.98	\$494.49	\$494.49	\$988.98		
Low Option Plan		\$386.86	\$386.86	\$773.72	\$342.83	\$342.84	\$685.67		
* EPO Option Plan Ending 12/31/2025		\$502.17	\$502.17	\$1,004.34	\$445.02	\$445.03	\$890.05		
2 Party Premium									
Medical Plan and Carrier		Two Party No Medicare Retiree Premium	Two Party No Medicare Employer Premium	Total Monthly Premium	Two Party One on Medicare Retiree Premium	Two Party One on Medicare Employer Premium	Total Monthly Premium	Two Party with Medicare Retiree Premium	Two Party with Medicare Employer Premium
High Option Plan		\$1,061.16	\$1,061.16	\$2,122.32	\$997.66	\$997.66	\$1,995.32	\$988.98	\$988.98
Low Option Plan		\$735.75	\$735.75	\$1,471.50	\$691.72	\$691.73	\$1,383.45	\$685.67	\$685.67
* EPO Option Plan Ending 12/31/2025		\$955.03	\$955.03	\$1,910.06	\$897.88	\$897.89	\$1,795.77	\$890.04	\$890.05
Family Premium									
Medical Plan and Carrier		Family No Medicare Retiree Premium	Family No Medicare Employer Premium	Total Monthly Premium	One Medicare Two or More No Medicare Retiree Premium	One Medicare Two or More No Medicare Employer Premium	Total Monthly Premium	Two Party with Medicare Retiree Premium	Two Party with Medicare Employer Premium
High Option Plan		\$1,417.31	\$1,417.31	\$2,834.62	\$1,353.81	\$1,353.81	\$2,707.62	\$1,290.31	\$1,290.31
Low Option Plan		\$982.74	\$982.74	\$1,965.48	\$938.71	\$938.72	\$1,877.43	\$894.69	\$894.69
* EPO Option Plan Ending 12/31/2025		\$1,275.55	\$1,275.55	\$2,551.10	\$1,218.40	\$1,218.41	\$2,436.81	\$1,161.25	\$1,161.26
Presbyterian									
Single Premium									
Medical Plan and Carrier		Single No Medicare Retiree Premium	Single No Medicare Employer Premium	Total Monthly Premium	Single with Medicare Retiree Premium	Single with Medicare Employer Premium	Total Monthly Premium		
High Option Plan		\$451.22	\$451.22	\$902.44	\$399.87	\$399.87	\$799.74		
Low Option Plan		\$312.89	\$312.89	\$625.78	\$227.28	\$227.29	\$554.57		
2 Party Premium									
Medical Plan and Carrier		Two Party No Medicare Retiree Premium	Two Party No Medicare Employer Premium	Total Monthly Premium	Two Party One on Medicare Retiree Premium	Two Party One on Medicare Employer Premium	Total Monthly Premium	Two Party with Medicare Retiree Premium	Two Party with Medicare Employer Premium
High Option Plan		\$947.49	\$947.49	\$1,894.98	\$896.14	\$896.14	\$1,792.28	\$799.74	\$799.74
Low Option Plan		\$656.95	\$656.95	\$1,313.90	\$621.34	\$621.35	\$1,242.69	\$554.56	\$554.57
Family Premium									
Medical Plan and Carrier		Family No Medicare Retiree Premium	Family No Medicare Employer Premium	Total Monthly Premium	One Medicare Two or More No Medicare Retiree Premium	One Medicare Two or More No Monthly Employer Premium	Total Monthly Premium	Two Medicare One or more No Medicare Retiree Premium	Two Medicare One or more No Medicare Employer Premium
High Option Plan		\$1,263.42	\$1,263.42	\$2,526.84	\$1,212.07	\$1,212.07	\$2,424.14	\$1,160.72	\$1,160.72
Low Option Plan		\$875.99	\$875.99	\$1,751.98	\$840.38	\$840.39	\$1,680.77	\$804.77	\$804.78
Blue Cross Blue Shield Dental									
Dental Carrier		Retiree Premium	Employer Premium	Total Monthly Premium	Two Party Retiree Premium	Two Party Employer Premium	Total Monthly Premium	Family Retiree Premium	Family Employer Premium
High Option Plan		\$14.43	\$14.43	\$28.86	\$27.46	\$27.46	\$54.92	\$43.14	\$43.14
Low Option Plan		\$7.23	\$7.23	\$14.46	\$13.75	\$13.75	\$27.50	\$21.57	\$21.57
Delta Dental									
Dental Carrier		Retiree Premium	Employer Premium	Total Monthly Premium	Two Party Retiree Premium	Two Party Employer Premium	Total Monthly Premium	Family Retiree Premium	Family Employer Premium
High Option Plan		\$14.59	\$14.59	\$29.18	\$27.77	\$27.77	\$55.54	\$43.63	\$43.63
Low Option Plan		\$7.31	\$7.31	\$14.62	\$13.91	\$13.91	\$27.82	\$21.82	\$21.82
United Concordia									
Dental Carrier		Retiree Premium	Employer Premium	Total Monthly Premium	Two Party Retiree Premium	Two Party Employer Premium	Total Monthly Premium	Family Retiree Premium	Family Employer Premium
High Option Plan		\$16.39	\$16.39	\$32.78	\$31.19	\$31.19	\$62.38	\$49.01	\$49.01
Low Option Plan		\$8.21	\$8.21	\$16.42	\$15.62	\$15.62	\$31.24	\$24.52	\$24.52
Davis Vision Plan									
Vision Carrier		Retiree Premium	Employer Premium	Total Monthly Premium	Two Retiree Premium	Two Employer Premium	Total Monthly Premium	Family Retiree Premium	Family Employer Premium
Davis Vision		\$3.23	\$3.23	\$6.46	\$5.40	\$5.40	\$10.80	\$7.28	\$7.28
Retiree Life Insurance									
Life Insurance Carrier					Retiree Premium	Employer Premium	Total Monthly Premium		
The Standard					\$1.16	\$0.00	\$1.16		