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**