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 Cvg Eff. Date (mm/dd/yyyy)
	$	$	$	$	$			

New Mexico Public Schools Insurance Authority
EMPLOYEE CHANGE CARD

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

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

1 **Social Security Number** | **Name (Last, First, Middle)** | **Date of Birth**

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 only if you do NOT wish to receive plan communications by e-mail. | **Work Phone Number** | **Cell Phone Number**

REASON FOR CHANGE:
☐ Late Enrollment ☐ New address and/or phone number
☐ Open/Switch Enrollment ☐ Qualifying Event

Answer questions below
What event took place?
What date did event take place?

2 **ENROLLMENT**

What is your current enrollment status? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)
What enrollment status are you requesting? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

Check One: ☐ **ADD COVERAGE** ☐ **CANCEL COVERAGE** ☐ **SWITCH ENROLLMENT**

☐ BASIC LIFE: The Standard $50,000 ☐ Decline Basic Life

MEDICAL:
☐ **Blue Cross Blue Shield of NM** ☐ High Option (*Default*) ☐ Low Option ☐ EPO Option
☐ **Cigna** ☐ High Option Plan (*Default*) ☐ Low Option Plan
☐ **Presbyterian** ☐ High Option (*Default*) ☐ Low Option
☐ Decline Medical
Reason: _____
Eligible for Medicaid? ☐ Yes ☐ No

DENTAL: **Delta Dental:** ☐ High Option (*Default*) ☐ Low Option **United Concordia:** ☐ High Option (*Default*) ☐ Low Option ☐ Decline Dental

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

☐ **LONG TERM DISABILITY**: **The Standard** (Qualifying Event or Evidence of Insurability) 90 Day BWP ☐ Decline Long Term Disability

☐ **ADDITIONAL LIFE**: **The Standard** (Qualifying Event or Evidence of Insurability) **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

3 **DEPENDENT INFORMATION** **List all dependents you wish to enroll.** Provide requested information for additional dependents on separate sheet if necessary. **Indicate an A (add), D (drop), C (continue coverage), or N/A (not applicable) for all names listed below.**

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, Loss of Coverage, or Court Order Attached
☐	☐	☐	☐				☐ F ☐ M		☐ Yes ☐ No
☐	☐	☐	☐				☐ F ☐ M		☐ Yes ☐ No
☐	☐	☐	☐				☐ F ☐ M		☐ Yes ☐ No
☐	☐	☐	☐				☐ F ☐ M		☐ Yes ☐ No

4 **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 QUALIFYING EVENT

5 **EMPLOYER CERTIFICATION** **ONLY complete this section for QUALIFYING EVENTS: Part-time to Full-time with a salary increase; Promotion into a new job class with a salary increase; Decrease in salary and hours worked per week. 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 he 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:**