



New Mexico Public Schools Insurance Authority
ACTIVELY SERVING BOARD MEMBER ENROLLMENT APPLICATION

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

Effective Date of Coverage
(in mm/dd/yyyy format)

1

Social Security Number		Name (Last, First, Middle)			Date of Birth (mm/dd/yyyy)
Mailing Address				City	State
		Zip Code	Phone Number		
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> F <input type="checkbox"/> M	School District/Educational Entity you represent			Date of Oath of Office (mm/dd/yyyy)
E-Mail Address <u>Mandatory</u> (Do not block emails from no-reply@easipta.com)					Date Current Term Expires (mm/dd/yyyy)

2 ENROLLMENT STATUS

Board Member Only 2-Party (Board Member + Spouse or Child) Family (Board Member + 2 or more)

↑ Be sure to complete dependent information in Box 4 ↑

3 ENROLLMENT Elect your coverage offered by the district/entity you represent

MEDICAL: **Blue Cross Blue Shield of NM** **Presbyterian** **Decline Medical. Reason for declining coverage:** _____
 Select One High Option (default) High Option (default)
 Low Option Low Option
 Exclusive Provider Option (EPO)

DENTAL: **Delta Dental** **United Concordia** **Decline Dental Coverage**
 High Option (default) High Option (default)
 Low Option Low Option

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

ADDITIONAL LIFE: **The Standard** (Complete Schedule A Beneficiary Form) **Decline Employee Additional Life**
 You may enroll for the amount of basic life coverage carried by the district/entity you represent. Check below for spouse and/or child life coverage
 Spouse (50% of member coverage) **Child (\$5,000 per child)** **Decline Dependent Life**

4 DEPENDENT INFORMATION

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
			<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
			<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No

5 METHOD OF PAYMENT

Your first payment must accompany your enrollment form. Make check or money order payable to NMPSIA and mail to the following address: **NMPSIA Eligibility Administrative Office; P. O. Box 9054; Santa Fe, NM 87504-9054**. Once enrolled, you will be asked to make a Method of Payment Election to choose to pay by a) bank debit of your checking account, b) pay for 6 months in advance, c) pay for 12 months in advance, or d) pay by check or money order via a monthly coupon book.

6 BOARD MEMBER AUTHORIZATION STATEMENT

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.**

BOARD MEMBER SIGNATURE _____ DATE _____

Please note: You will be eligible for coverage **until the last day of the month your term of office expires**. Please contact the NMPSIA Eligibility Administrative Office at (800) 233-3164, or at the address listed below when your term of office expires.

RETURN THIS FORM TO: NMPSIA Eligibility Administrative Office; P. O. Box 9054; Santa Fe, NM 87504-9054

Please read the NMPSIA Program Guide as you complete this enrollment application.

This Guide outlines the NMPSIA Eligibility Rules and administrative guidelines for enrollment.

ELIGIBILITY

If you are a newly elected board member, you must sign and mail this form to the following address within 31 days from the date you take office: **NMPSIA Eligibility Office; P. O. Box 9054; SantaFe, NM 87504-9054.** If you are also enrolling a spouse and/or children, you need to provide the necessary supportive documentation (marriage certificate, proof of birth, etc.). If you are reporting a change in status, you must mail this form with any supportive documentation within 31 days from your qualifying event.

To be eligible for NMPSIA Group Coverage, you must be an actively serving Board Member.

EFFECTIVE DATE OF COVERAGE AND PREMIUM PAYMENT

Your effective date of coverage can be as early as the first of the month following the date you take office, provided that you mail your application and premium payment to us prior to your effective date.

When your application and supportive documentation (if required) arrives at our office with your premium payment, our office will mail you a Method of Payment Election form to choose a payment option as described in the enrollment application. If you have any questions about this process, please contact us at **1-(800) 233-3164**.

ENROLLMENT

You may only apply for the lines of NMPSIA coverage offered by the school district/educational entity you represent. Basic life coverage and long term disability coverage is not available to you. Please keep the following in mind:

- If you decline medical coverage within 31 days from becoming eligible, you may apply to enroll in NMPSIA medical coverage within 31 days from a qualifying event or special enrollment event, or enroll during the open enrollment for medical in the fall with an effective date of January 1st.
- You may enroll as board member only for any line of NMPSIA coverage.
- If you enroll in vision coverage, you and each of your enrolled dependents must meet the 24-month enrollment requirement before you can cancel this coverage.
- If you enroll for additional life (ADL) coverage, you may apply for coverage up to the amount of basic life coverage your district/entity offers to its employees. You may also apply for life coverage for your spouse at the rate of 50% of your (ADL) coverage. You may also insure your dependent children for \$5,000 of life coverage.
- If you decline (ADL) coverage, you may apply through the evidence of insurability process. The life insurance carrier will make a determination on this application.
- If you decline dental and/or vision coverage, you may not enroll late to either of these plans unless you apply within 31 days from involuntarily losing other dental and/or vision coverage, or enroll during the open enrollment for dental/vision in the fall with an effective date of January 1st.

To enroll your spouse and/or your married or unmarried children who are up to 26 years old for any line of NMPSIA coverage offered by the school district/educational entity you represent, you will be required to present the supportive documentation to prove eligibility for your dependents.

Indicate the status (board member only, two-party, or family) for each line of coverage. If you enroll one eligible dependent, you must enroll all eligible dependents, unless one or more dependents have other coverage. When enrolling dependents, you may exclude a dependent from a particular line of NMPSIA coverage only if you provide evidence that the dependent you are excluding has that particular line of coverage elsewhere. In this case, evidence of the other coverage is required (*i.e., letter of insurance verification, insurance ID card with dependent's name listed, etc.*). If you are excluding a dependent and do not provide this evidence, the dependents you are enrolling will suffer a delay in coverage until such evidence is provided. Further, there is a 61-day deadline from your effective date of coverage to provide such evidence.

If your spouse works for a NMPSIA affiliated employer, you and your spouse cannot double insure each other and your dependents under the NMPSIA Group Plan for any line of NMPSIA coverage.

To enroll your spouse, present your **official state publicly filed marriage certificate** (*from the County Clerk's Office*). You may provide a chapel marriage certificate, but NMPSIA reserves the right to request the official state copy at any time.

If you divorce, you must report this within 31 days and cancel coverage for your ex-spouse effective the last day of the month the divorce is final. You will be required to provide copies of certain pages of your final divorce decree. Covering an ex-spouse is considered misrepresentation.

To enroll your married or unmarried children (*who are up to 26 years old*) for any line of NMPSIA coverage offered by the school district/educational entity you represent, present their **official state publicly filed birth certificates** (*from the Bureau of Vital Statistics*). You may provide hospital birth certificates, but NMPSIA reserves the right to request the official state copy at any time.

Coverage for your dependents will begin on your effective date of coverage when you provide the appropriate supportive documentation at the time of application or prior to your coverage going into effect. You have 61 days from your effective date of coverage or 61 days from your qualifying event to provide the appropriate supportive documentation for your dependents, but their effective date of coverage will be on the first day of the month following the date you provide this documentation. Coverage for your dependents will not be made retroactive. If you do not provide this information within 61 days, you may apply to cover your dependents during the established open enrollment period in the fall for coverage that will become effective on January 1.

PRESCRIPTION DRUG COVERAGE – If you enroll in the medical plan, you are automatically enrolled in the Prescription Drug Program. You will receive a separate ID card from the NMPSIA Prescription Drug Manager to purchase your prescription drugs.

BENEFICIARY DESIGNATION FOR LIFE COVERAGE

Complete attached **Schedule A** form to make your selection(s) for your beneficiary for additional life coverage. You may change your beneficiary designation at any time. If you do not designate a beneficiary for your life insurance, the life insurance carrier will apply its established processes to determine the individual(s) entitled to your life benefit.

CONFIRMATION OF ENROLLMENT

Once your enrollment has been processed, the NMPSIA Eligibility Administrative Office will email you or mail you a Confirmation of Enrollment Notice to your home. Please review this confirmation notice carefully and report any discrepancies to the NMPSIA Eligibility Administrative Office at 1(800)233-3164.

If you do not provide the NMPSIA Eligibility Administrative Office with all of the appropriate documentation necessary to finalize your enrollment request, you will be contacted for the appropriate documentation. Please be sure to adhere to all deadlines associated with this request.



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 (Board Member)

Board Member Social Security Number	Board Member Name	School/Entity Serving
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 Board Member	Phone Number	Address	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 Board Member	Phone Number	Address	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.

BOARD MEMBER SIGNATURE: _____

DATE: _____

Witnessed by School/Entity: _____

DATE: _____

IMPORTANT NOTE: Community Property Laws are applicable to Board Members 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 Eligibility Administrative Office, P.O. Box 9054, Santa Fe, NM 87504-9054