NMPSIA Employee Change Card

https://nmpsia.com/pdfs/1.1.2021_Change_Card_2020-09-13.pdf

District Name and District Number

Other coverage effective date

What Event took place?
What date did event take place?

Section 3 Dependent Information reflects selection of Section 2 Enrollment Status

Removing ineligible dependents may also apply to any ancillary benefits your employer offers

Employer is responsible to complete the EMPLOYER CERTIFICATION section after verifying the form is completed in its entirety

Date stamp upon receipt

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

New Mexico Public Schools Insurance Authority
EMPLOYEE CHANGE CARD

District/Entity Name | District/Entity #

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 ☐ 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

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) ☐ Decline Long Term Disability

☐ ADDITIONAL LIFE: The Standard (Qualifying Event or Evidence of Insurability) Select: ☐ 1X ☐ 2X ☐ 3X Base Annual Salary ☐ Spouse Life ☐ 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 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
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BENEFITS SPECIALIST SIGNATURE: DATE:

Revised September 2020