New Mexico Public Schools Insurance Authority
Retiree Life Insurance Application

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

EFFECTIVE DATE (in mm/dd/yyyy format)
EMPLOYER NO.

RETIREE INFORMATION

SOCIAL SECURITY NO.	NAME (Last, First, Middle)			
MAILING ADDRESS (Box # or street address)	CITY	STATE	ZIP	COUNTY

DATE OF BIRTH (mm/dd/yyyy)	MARITAL STATUS	GENDER	E-MAIL	HOME PHONE
	☐ Single ☐ Married	☐ Male ☐ Female	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.	

SCHOOL / EMPLOYER	DATE OF RETIREMENT (mm/dd/yyyy)	DATE OF TERMINATION OF COVERAGE (mm/dd/yyyy)

ENROLLMENT

This Additional Life insurance continuation ends with NMPSIA when you reach the limiting age of age 65*.
* Age 70 for employees who retire from the Clovis, Dora, or Portales School District.

Retiree Additional Life – **(Maximum Benefit $300,000)**	Spouse Additional Life	Dependent Children
SELECT ONE: ☐ 1X Last Contracted Salary ☐ 2X Last Contracted Salary ☐ 3X Last Contracted Salary	(Coverage is equivalent to the lesser of 1X or 50% of the Retiree Amount not to exceed the retiree's last contracted salary) ☐ Yes ☐ No	☐ Yes ☐ No

ADDITIONAL LIFE INSURANCE COVERAGE CONTINUED FOR THE FOLLOWING DEPENDENT(S):

Name (Last, First, Middle)	Social Security Number	Date of Birth	Gender	Relationship To You

PRIMARY BENEFICIARY

FULL NAME		RELATIONSHIP		
MAILING ADDRESS	STREET OR P. O. BOX NUMBER	CITY	STATE	ZIP CODE

SECONDARY BENEFICIARY (In the event the primary beneficiary designated above is not living at the time of the insured's death)

FULL NAME		RELATIONSHIP		
MAILING ADDRESS	STREET OR P. O. BOX NUMBER	CITY	STATE	ZIP CODE

APPLICATION INFORMATION: This application and premium must be postmarked no later than 31 days from the date your Additional Life coverage terminated with your employer.

PREMIUM INFORMATION: The NMPSIA Eligibility Administrative Office will e-mail or mail you a Confirmation of Enrollment upon receipt of your application notifying you whether or not you are eligible for Additional Life coverage. You will be required to pay the full monthly premium to NMPSIA. The amount may change in accordance with any premium rate changes for the Group Plan. Your premium payment is due by the 1st of each month.

METHOD OF PAYMENT: Your first payment must accompany your enrollment form. Make your 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 either pay by Bank Debit from your bank account, pay for 6 months in advance, or pay for 12 months in advance.

MEMBER AUTHORIZATION: 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 supporting documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature of Retiree ____________________ **Date** ____________________