Print Form

# State of New Mexico Enrollment/Change Form

*State Agency & LPB Enrollment/Change forms must be completed electronically. No hand-written forms will be accepted or processed.*

☐ New Application ☐ Reinstatement ☐ Transfer ☐ Late Enrollment ☒ Changes to Enrollment see box 12 for reason

*Please type form completely*

## Section A: EMPLOYEE INFORMATION

| 1. Social Security Number | 2. Employee (Last, First, M.I.) | 3. Date of Birth (Mo Day Yr) | 4. Sex | 5. Marital Status |
|---|---|---|---|---|
| 585 – 58 – 5423 | Garcia, Marie A | 09 / 17 / 53 | ☐ M ☒ F | ☐ Married ☒ Single |

| 6. Mailing Address (Street) | (City) | (County) of physical residence | (State) | (Zip) |
|---|---|---|---|---|
| PO Box 5621 | Santa Fe | | NM | 87502 |

| 7. Home Phone ( ) - | Work Phone ( ) - | Cell Phone ( ) - |
|---|---|---|

| 8. Agency Code | 9. LPB Code | 10. Hire Date (Mo Day Yr) | 11. Effective Coverage/Change (Mo Day Yr) | 12. Reason for Change | 13. Annual Salary |
|---|---|---|---|---|---|
| | | / / | / / | Increase Supp to level 2 | $ |

## Section B: MEDICAL

| ☐ Waiver of Medical/Drug/Mental Health Coverage - *A check in this box waives my enrollment in this benefit plan.* ***NOTE: If you waive this coverage you must answer the questions in Section H.*** | Single | Employee + Sp/Partner | Employee + Child | Family |
|---|---|---|---|---|
| ☒ Presbyterian Health Plan -HMO | ☐ | ☐ | ☒ | ☐ |
| ☐ Lovelace Health Plan -HMO | ☐ | ☐ | ☐ | ☐ |
| ☐ Blue Cross Blue Shield of New Mexico-PPO | ☐ | ☐ | ☐ | ☐ |

If electing medical, you must elect Basic Life in Section F

## Section C: DENTAL

| ☐ Waiver of Dental - *A check in this box waives my enrollment in this benefit plan. Go to Section H to complete.* | Single | Employee + Sp/Partner | Employee + Child | Family |
|---|---|---|---|---|
| ☒ Enroll me in Delta Dental of New Mexico | ☐ | ☐ | ☒ | ☐ |

## Section D: VISION

| ☐ Waiver of Vision - *A check in this box waives my enrollment in this benefit plan.. Go to Section H to complete.* | Single | Employee + Sp/Partner | Employee + Child | Family |
|---|---|---|---|---|
| ☒ Enroll me in Vision Service Plan (VSP) | ☐ | ☐ | ☒ | ☐ |

## Section E: LEGAL

| ☐ Waiver of Legal - *A check in this box waives my enrollment in this benefit plan.* | Single | Employee + Sp/Partner | Employee + Child | Family |
|---|---|---|---|---|
| ☒ Enroll me in ARAG Legal Plan | ☒ | ☐ | ☐ | ☐ |
| ☐ ARAG Legal PLUS Senior Advocate | ☐ | ☐ | ☐ | ☐ |

## Section F: LIFE & DISABILITY

☒ Basic Life & Disability *(Employee Only)*

☒ Dependent Life *(Spouse/DP may need EOI form)*

☒ Supplemental Life *(select level)* *May need Evidence of Insurability Form* ☐ Sup 1 ☒ Sup 2 ☐ Sup 3 ☐ Sup 4 ☐ Sup 5

## Section G: IF YOU MADE A SELECTION ABOVE, LIST ALL DEPENDENTS TO BE COVERED, INCLUDING YOUR SPOUSE or DOMESTIC PARTNER.

Indicate with an A (add) or D (drop) under the corresponding choice, whether you are adding or dropping the listed dependent from the plan.

A=Add D=Drop NA=Not Selecting Relationship Codes: 1=Employee, 2=Spouse, 3=Son, 4=Daughter, 5=Domestic Partner, 6 =Domestic Partner Child

| Med Pkg | Dent | Vision | Life Dis | Legal | Social Security No. | Name (Last Name, First Name, MI) | Sex M or F | Rel. Code 1- 6 | Date of Birth |
|---|---|---|---|---|---|---|---|---|---|
| A | A | A | A | A | Employee 585-58-5423 | Garcia, Marie A | F | 1 | 09 / 17 / 53 |
| | | | | | Spouse/Domestic Partner | | | | / / |
| A | A | A | A | D | Dependent 648-34-6549 | Hinojoza-Jaramillo, Janessa | F | 4 | 04 / 17 / 04 |
| | | | | | Dependent | | | | / / |
| | | | | | Dependent | | | | / / |
| | | | | | Dependent | | | | / / |
| | | | | | Dependent | | | | / / |
| | | | | | Dependent | | | | / / |

## Section H: OTHER COVERAGE INFORMATION

If you waived medical, dental and/or vision coverage, do you have coverage through another means? ☐ Yes ☐ No

If you answered YES, with whom do you have coverage? _____

If you answered NO, why did you waive coverage? _____

Employee Authorization for release of medical information and payroll deduction: I apply for the coverage offered to me and my dependents shown above and my employer to periodically deduct from my earnings, on a pre-tax basis (POP) unless waived in writing, until further notice, amounts equal to required contributions. I understand that services will be available subject to exclusions, limitations, and conditions described in the summary plan description. I authorize any hospital, physician, dentist, or other health care provider to furnish, when applicable and follow HIPAA privacy regulations, medical information regarding me and my dependents necessary to process claims. I authorize the carrier to coordinate benefits and/or reimbursements with other health or dental plans or insurance companies. I certify that the above information is correct to the best of my knowledge and belief.

RMD is required by Federal Law to maintain and protect the privacy of your health information and provide you with notice of its legal duties and privacy practices. If you have any questions regarding this notice or the privacy of your health information, please contact RMD at PO Box 6850, Santa Fe, NM 87502, or by telephone at 1-877-301-8041.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, Insurance Fraud will be prosecuted to the fullest extent of the law and will prohibit access to RMD Benefits in the future. By waiving any coverage above, I understand I may not be able to enroll in this benefit plan until a future open enrollment date.

Employee's Signature _____ Date _____

For Employer's Payroll Deduction Authorization and Acceptance of Insurance Fraud Statement

Signed original Enrollment/Change Form on file in employee's personnel or medical file at employer's Human Resources office.