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 By Approval Only ☐ Transfer ☐ 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 ☐M ☐F	5. Marital Status ☐ Married ☐ Single

6. Mailing Address (Street)	(City)	(County) of physical residence	(State)	(Zip)

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 $

Section B: MEDICAL

☐ Waiver of Medical/Pharmacy - *An "X" in this box waives my enrollment in this benefit plan. Go to Section F to complete.*

NOTE: If you waive this coverage, please answer the questions in Section G.

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Presbyterian Health Plan -HMO Note: If electing NMHIP, please use NMHIP Enrollment Applications	☐	☐	☐	☐
☐ Lovelace -HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - PPO	☐	☐	☐	☐

☐ Basic Life *(Employee Only)* ***If electing Medical: Life coverage must also be elected. If election is not being done at time of hire; EOI process is required. See HR for guidance.***

☐ Dependent Life ***If electing Dep Medical: Dep Life coverage must also be elected. NOTE:*** *Spouse/DP:* ***If election is not due to new hire,*** marriage/***DP affidavit; EOI process is required. See HR for guidance.***

Section C: DENTAL

☐ Waiver of Dental - *An "X" in this box waives my enrollment in this benefit plan. Go to Section F to complete.*

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Enroll me in Delta Dental of New Mexico	☐	☐	☐	☐

Section D: VISION

☐ Waiver of Vision - *An "X" in this box waives my enrollment in this benefit plan.. Go to Section F to complete.*

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Enroll me in Vision Service Plan (VSP)	☐	☐	☐	☐

Section E: LIFE & DISABILITY

☐ Basic Life *(Employee Only)*

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

☐ Disability *(Employee Only)*

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

Section F: 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	Dis	Life/ Dep Life	Social Security No.	Name (Last Name, First Name, MI)	Sex M or F	Rel. Code 1- 6	Date of Birth
					Employee				/ /
					Spouse/Domestic Partner				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /

Section G: 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 Enrollment/Change Form on file with Third Party Administrator, and a copy in employee's personnel or medical file at employer's Human Resources office.