For Employer Use:	MEDICAL	DENTAL	VISION	DISABILITY	VOLUNTARY LIFE	Former Employer (if covered under NMPSIA)	Basic Life Eff. Date	Other Coverage Eff.
PAYROLL DEDUCTIONS:	$	$	$	$	$			

New Mexico Public Schools Insurance Authority
EMPLOYEE CHANGE CARD

Eligibility Administrator 505-988-4974 1-800-233-3164 Fax 505-988-8943

District/Entity Name	District/Entity #

1

Social Security #	Name (Last, First, Middle)			Date of Birth
Mailing Address	**City**	**State**	**Zip Code**	**Phone #**

Marital Status	Gender	Job Title	Date of Hire (first day of contract)	Base Annual Salary	# of hours contracted to work weekly
❑ S ❑ M	❑ F ❑ M			$_____ Do not prorate or include increments and stipends (i.e. coaching, prep. time, etc.)	____

REASON FOR CHANGE:
- ❑ **Late Enrollment**
- ❑ **Switch Enrollment**
- ❑ **New address and/or phone #**
- ❑ **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

❑ ADDITIONAL LIFE: The Standard Select: ❑1 x ❑2 x ❑3x Base Annual Salary ❑Spouse Life ❑Child Life

MEDICAL: ❑High Option (Default) ❑Low Option ❑NM Blue Cross Blue Shield ❑Presbyterian

DENTAL: United Concordia ❑High Option (Default) ❑Low Option

❑VISION: Davis Vision (2 year enrollment required)

❑LONG TERM DISABILITY: The Standard

❑Delcine Employee Additional Life

❑Delcine Dependent Life

❑Decline Medical

❑Decline Dental

❑Decline Vision

❑Decline Long Term Disability

3 DEPENDENT INFORMATION

Dependent's Name (Last, First, Middle)	Social Security #	Date of Birth	Gender	Dependent's Relationship To You	Proof of Marriage, Birth, Loss of Coverage or Court Order Attached	Employer Comments
			❑ F ❑ M		❑ Yes ❑ No	
			❑ F ❑ M		❑ Yes ❑ No	
			❑ 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 depedents. 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.**

EMPLOYEE SIGNATURE _____ **DATE** _____

RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR QUALIFYING EVENT

5 EMPLOYER CERTIFICATION: 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.

BENEFITS SPECIALIST SIGNATURE _____

DATE _____

Date Received in Your Office (Apply Date Stamp)

Effective July 2008