Benefits Enrollment/Change Form for LPB/Legislators

Enrollment/Change forms must be completed electronically and to its entirety. No hand-written forms will be accepted or processed.

Section A: EMPLOYEE INFORMATION

Social Security No.	2. Employee (Last, First, M.I.)	3. Date of Birth	4. Sex ☐ M ☐ F	5. Marital Status ☐ Married ☐ Single

6. Mailing Address	City	County of physical residence	State	Zip

7. Home Phone	Work Phone	Cell Phone	Preferred Phone

8. LPB Code	9. Hire Date	10. Effective Coverage/Change Date	11. Reason for Change	12. Annual Salary $

Section B: MEDICAL

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Waiver of Medical/Pharmacy - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Presbyterian Health Plan - HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - PPO	☐	☐	☐	☐

Section C: DENTAL

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Waiver of Dental - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Enroll me in Delta Dental of New Mexico	☐	☐	☐	☐

Section D: VISION

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Waiver of Vision - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Enroll me in Vision Service Plan (VSP)	☐	☐	☐	☐

Section E: LIFE

☐ Basic Life *(Employee Only)*

New life carrier is Minnesota Life/Securian.

Information regarding your Life coverage options can be found at https://www.mybenefitsnm.com/2015_OpenSwitchEnrollment.htm

For Enrollment/Change in Additional (Supplemental) Life and Dependent Life coverage please visit http://lifebenefits.com/plandesign/SONM

NOTE : Dependent children can be added at any time. Please contact Minnesota Life to add dependents children.

Section F: DISABILITY (For Employee Only)

☐ Waiver of Disability - *An "X" in this box waives my enrollment in this benefit plan.*

☐ Enroll me in Disability - Check with your HR Rep for Disability Guidelines

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

NOTE: Proof of dependency documentation, for dependents not previously covered under any benefit coverage, must be submitted to your Human Resources representative along with your enrollment form. Legislators must fax enrollment form and all dependent documentation to Erisa at (505) 244-6009.

Indicate with an A (add), D (drop), C (continue coverage), NA (not applicable) for all names listed below.

Relationship Codes: 1=Employee, 2=Spouse, 3=Son, 4=Daughter, 5=Domestic Partner, 6 =Domestic Partner Child

Med	Dental	Vision	Dis		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				

Employee/Legislator Authorization for release of medical information and payroll deduction (for LPB Employees): I apply for the coverage offered to me and my dependents shown above and allow my employer to periodically deduct from my earnings, on a pre-tax basis (for LPB Employees) 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

Fax signed Enrollment/Change Form to Third Party Administrator (505-244-6009), and place a copy in employee's personnel or medical file at employer's Human Resources office.