State of New Mexico LBP Enrollment/Change Form for January 1 - December 31, 2014

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

☐ New Application ☐ Changes to Enrollment see box 12 for reason

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. LPB Code	9. Hire Date Mo Day Yr / /	10. Effective Coverage/Change Mo Day Yr	11. Reason for Change	12. Annual Salary
		1/1/2014	CY14 Open/Switch Enrollment	$

Section B: MEDICAL

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

	Single	Employee + Sp/Partner	Employee + Child	Family
☐ Presbyterian Health Plan -HMO	☐	☐	☐	☐
☐ Lovelace -HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - PPO	☐	☐	☐	☐

Section C: DENTAL

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

Section E: LIFE

Enrollment in Basic Life, Additional (Supplemental) Life and Dependent Life coverage is not available for enrollment or change (to existing coverage) at this time.

If enrollment or change is desired, it will have to be requested after 1/1/2014. Employees or dependent spouse/domestic partner who do not currently have coverage will be required to submit an Evidence of Insurability (EOI). Dependent children can be added at anytime (after 1/1/2014) as long as the employee has life coverage at that time.

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.

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

NOTE: If enrolling new dependents to benefit coverage, proof of dependency documentation will have to be faxed to Erisa at (505) 244-6009 by Nov 15th

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				/ /

Employee Authorization for release of medical information and payroll deduction: 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 (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.