

# State of New Mexico Enrollment/Change Form

New Application    
  Reinstatement    
  Transfer    
  Late Enrollment    
  Changes to Enrollment

*Please fill this form out completely.*

## SECTION A: EMPLOYEE INFORMATION

1. Social Security Number - -	2. Employee (Last, First, M.I.)	3. Date of Birth Mo Day Yr / /	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
6. Mailing Address (Street)		(City)	(County) of physical residence	(State) (Zip)	
7. Agency Code	8. LPB Code	9. Hire Date Mo Day Yr / /	10. Effective Coverage/Change Mo Day Yr / /	11. Reason for Change	12. Annual Salary

## SECTION B: MEDICAL

Waiver of Medical/Drug/Mental Health Coverage – A check in this box waives my enrollment in this benefit plan.     Single    Employee + Spouse    Employee + Child    Family  
*NOTE: If you waive this coverage, you must answer the questions in Section H.*

<input type="checkbox"/> Presbyterian – HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lovelace – HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blue Cross Blue Shield of New Mexico – PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> United HealthCare – PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SECTION C: DENTAL

Waiver of Dental – A check in this box waives my enrollment in this benefit plan.     Single    Employee + Spouse    Employee + Child    Family

Enroll me in Delta Dental                   

## SECTION D: VISION

Waiver of Vision – A check in this box waives my enrollment in this benefit plan.     Single    Employee + Spouse    Employee + Child    Family

Enroll me in Vision Service Plan                   

## SECTION E: LEGAL

Waiver of Legal – A check in this box waives my enrollment in this benefit plan.     Single    Employee + Spouse    Employee + Child    Family

Enroll me in ARAG Legal Plan                   

ARAG Legal PLUS Senior Advocate                   

## SECTION F: LIFE & DISABILITY

<input type="checkbox"/> Basic Life & Disability (Employee Only)	<input type="checkbox"/> Sup 1	<input type="checkbox"/> Sup 2	Beneficiary 1	%
<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Sup 3	<input type="checkbox"/> Sup 4	Beneficiary 1	%
<input type="checkbox"/> Supplemental Life (select level)	<input type="checkbox"/> Sup 5		Beneficiary 1	%

## SECTION G: IF YOU MADE A SELECTION ABOVE LIST ALL DEPENDENTS TO BE COVERED INCLUDING YOUR SPOUSE.

Indicate with an A (add) or D (delete) under the corresponding choice, whether you are adding or deleting the listed dependent from the plan.  
 A=Add D=Delete Relationship Codes: 1=Employee, 2=Spouse, 3=Son, 4=Daughter, 5=Domestic Partner, 6=Domestic Partner Child

Med Pkg	Den	Vision	Life	Legal	Social Security No.	Name (Last, First, MI)	Sex	Rel.	Date of Birth
					Employee				/ /
					Spouse				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /
					Dependent				/ /

## SECTION H: OTHER COVERAGE INFORMATION

If you waived medical 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 following 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 \_\_\_\_\_