

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/Department	8. Payroll Branch Code	9. Hire Date Mo Day Yr / /		10. Effective Date of Coverage/Change Mo Day Yr / /		11. Reason for Change				12. Annual Salary		

SECTION B: MEDICAL/DRUG/MENTAL HEALTH PLAN PACKAGES					
<input type="checkbox"/> Waiver of Medical/Drug/Mental Health Coverage - <i>A check in this box waives my enrollment in this benefit plan.</i>			Single	Employee + 1	Family
<input type="checkbox"/> Presbyterian - HMO - Statewide			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cigna - Open Access Plus - Statewide			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blue Cross Blue Shield of New Mexico - PPO - Statewide			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C: DENTAL PLAN (2 CHOICES)					
<input type="checkbox"/> Waiver of Delta Dental Coverage - <i>A check in this box waives my enrollment in this benefit plan.</i>			Single	Employee + 1	Family
<input type="checkbox"/> Enroll me in the Delta Dental Comprehensive			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: VISION					
<input type="checkbox"/> Waiver of Vision Coverage - <i>A check in this box waives my enrollment in this benefit plan.</i>			Single	Employee + 1	Family
<input type="checkbox"/> Enroll me in the The Vision Service Plan			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION E: LEGAL					
<input type="checkbox"/> Waiver of Legal Coverage - <i>A check in this box waives my enrollment in this benefit plan.</i>			Single	Employee + 1	Family
<input type="checkbox"/> Enroll me in ARAG Legal Plan			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Legal Plus Senior Advocate			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION F: LIFE & DISABILITY				
<input type="checkbox"/> Enroll me in Basic Life & Disability (Employee Only)		<input type="checkbox"/> Sup 1 <input type="checkbox"/> Sup 2 <input type="checkbox"/> Sup 3 <input type="checkbox"/> Sup 4 <input type="checkbox"/> Sup 5 <input type="checkbox"/> Dependent Life (See Below)	Beneficiary 1	%
			Beneficiary 2	%
			Beneficiary 3	%

SECTION G: IF YOU MADE A SELECTION IN SECTIONS B, C, D, E & F 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	Legal	Life	Social Security No.	Name (Last, First, M.I.)	Sex	Rel.	Date of Birth	PCP Code
					Employee				Mo Day Yr	1.
					Spouse				/ /	2.
					Dependent				/ /	1.
					Dependent				/ /	2.
					Dependent				/ /	1.
					Dependent				/ /	2.
					Dependent				/ /	1.
					Dependent				/ /	2.

SECTION H: OTHER COVERAGE INFORMATION

Is anyone listed on this application covered under any other health insurance, government program, medicare, medicaid or other private insurance?

Yes No

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 the 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 Drawer 26110, Santa Fe, NM 87502-0110, 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 _____

White: Agency Copy
 Canary: Employee Copy