

# Benefits Enrollment Form for 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

|                                     |                                 |                                    |                                                                 |                                                                                       |                                |
|-------------------------------------|---------------------------------|------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------|
| SSN / ITIN                          | 2. Employee (Last, First, M.I.) | 3. Date of Birth                   | 4. Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | 5. Marital Status<br><input type="checkbox"/> Married <input type="checkbox"/> Single |                                |
| 6. Mailing Address (Street)         |                                 | City                               | County of physical residence                                    | State                                                                                 | Zip                            |
| 7. Home Phone                       |                                 | Work Phone                         | Cell Phone                                                      |                                                                                       | Preferred Phone                |
| 8. State Agency Code<br><b>L001</b> | 9. Hire Date                    | 10. Effective Coverage/Change Date | 11. Reason for Change                                           |                                                                                       | 12. Annual Salary<br><b>\$</b> |

## Section B: MEDICAL

|                                                                                                                     |                          |                          |                           |                          |
|---------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| <input type="checkbox"/> Waiver of Medical/Pharmacy - An "X" in this box waives my enrollment in this benefit plan. | Single                   | Employee + Sp/Partner    | Employee + Child/Children | Family                   |
| <input type="checkbox"/> Presbyterian Health Plan - HMO                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| <input type="checkbox"/> Blue Cross Blue Shield of New Mexico - 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"/> |

## Section C: DENTAL

|                                                                                                           |                          |                          |                           |                          |
|-----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| <input type="checkbox"/> Waiver of Dental - An "X" in this box waives my enrollment in this benefit plan. | Single                   | Employee + Sp/Partner    | Employee + Child/Children | Family                   |
| <input type="checkbox"/> Enroll me in Delta Dental of New Mexico                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

## Section D: VISION

|                                                                                                           |                          |                          |                           |                          |
|-----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| <input type="checkbox"/> Waiver of Vision - An "X" in this box waives my enrollment in this benefit plan. | Single                   | Employee + Sp/Partner    | Employee + Child/Children | Family                   |
| <input type="checkbox"/> Enroll me in EyeMed                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

## Section E: LIFE

☐ \$50K Basic Life

The Hartford is the carrier for life insurance benefits.

For additional information regarding the life benefit plan please go to: <https://www.mybenefitsnm.com> To enroll in Basic Life please check the box on this form.

Note: Dependent children can be added at any time. Please contact Erisa to add dependent children.

## Section F: 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 faxed to Erisa at (505) 244-6009 with the enrollment form**

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 | SSN / ITIN                  | Name (Last Name, First Name, MI) | Sex<br>M or F | Rel. Code<br>1- 6 | Date of Birth |
|-----|--------|--------|-----------------------------|----------------------------------|---------------|-------------------|---------------|
|     |        |        | Employee                    |                                  |               |                   |               |
|     |        |        | Spouse/<br>Domestic Partner |                                  |               |                   |               |
|     |        |        | Dependent                   |                                  |               |                   |               |
|     |        |        | Dependent                   |                                  |               |                   |               |
|     |        |        | Dependent                   |                                  |               |                   |               |
|     |        |        | Dependent                   |                                  |               |                   |               |
|     |        |        | Dependent                   |                                  |               |                   |               |
|     |        |        | Dependent                   |                                  |               |                   |               |

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 HCA Benefits in the future.

I have had the opportunity to ask questions about my benefit options and my enrollment elections reflect my informed decisions.

I understand that once I submit my enrollment information, including any waiver, I will have limited opportunities to change my enrollment elections other than during the open/switch enrollment in the fall of each year for benefit plan years starting each January 1st.

I reviewed the information I provided in this enrollment before submitting and I confirm that the information accurately reflects my elections

I understand that services will be available subject to exclusions, limitations, and conditions described in the summary plan descriptions (found on each carrier's website). I authorize any hospital, physician, dentist, or other health care provider to furnish, 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.

The State's Group Benefits Plan 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. The privacy notice is posted at [https://www.mybenefitsnm.com/Documents/HIPAA\\_Privacy\\_Notice.PDF](https://www.mybenefitsnm.com/Documents/HIPAA_Privacy_Notice.PDF) on the mybenefitsnm website. If you have any questions regarding this notice or the privacy of your health information, please contact HCA at PO Box 2348, Santa Fe, NM 87504, or by telephone at 505-827-2036.

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.