# LPB Enrollment Form

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

**Section A: EMPLOYEE INFORMATION, Dates are (MM/DD/YYYY)**

| 1. SSN / ITIN | 2. Employee Last | First, | M.I. | 3. Date of Birth | 4. Sex | 5. Marital Status |
|---|---|---|---|---|---|---|
| | | | | | | |

| 6. Mailing Address (Street) | City | County (if physical residence) | State | Zip |
|---|---|---|---|---|
| | | | | |

| 7. Home Phone | Work Phone | Cell Phone | Preferred Phone | Email Address |
|---|---|---|---|---|
| | | | | |

| 8. Agency | 9. Hire Date | 10. Job Title | 11. Annual Salary $ |
|---|---|---|---|
| | | | |

| 12. Effective Date | 13. Reason for Change | 14. Employee ID |
|---|---|---|
| | | |

**Section B: MEDICAL**

Medical Carrier:
- ☐ BCBS of New Mexico
- ☐ Presbyterian
- ☐ United Healthcare
- ☐ Waive Medical

Medical Plan:
- ☐ Clear Cost Platinum HMO
- ☐ Basic Gold HMO
- ☐ Basic Gold PPO
- ☐ HDHP Silver PPO

Coverage Tier:
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Family

**Section C: DENTAL**

Dental Carrier:
- ☐ Delta Dental
- ☐ Metlife Dental
- ☐ Waive Dental

Dental Plan:
- ☐ Basic PPO
- ☐ Buy-Up PPO

Coverage Tier:
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Family

**Section D: VISION**

Vision Carrier:
- ☐ Davis Vision
- ☐ WAIVE

Vision Plan:
- ☐ Basic
- ☐ Buy Up

Coverage Tier:
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Family

**Section E: DISABILITY (For Employees Only)**

Disability Status:
- ☐ Add or Continue
- ☐ Waive

**Section F: LIFE**

Employee Only; Automatic benefit 100% employer paid. The Hartford is the carrier for life insurance benefits.
For additional information regarding the life benefit plan please go to: https://www.mybenefitsnm.com/TermLife.html Note: Dependent children can be added at any time. Please contact EASI Gov to add dependent children.

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

Note: I have provided proof of dependency for newly covered dependents or making changes to existing coverage with enrollment form to EASI Gov via fax 505-244-6009.

Indicate Coverage with:
A (add), D (drop), C (continue), NA (not applicable).

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

| Med | Dental | Vision | Dis | SSN / ITIN | Name (Last, First, MI) | Sex | Rel. Code | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|---|---|---|---|---|
| | | | | | Employee | | | |
| | | | | | Spouse/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, have reviewed my enrollment information, and confirm that my elections accurately 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 acknowledge that it is my responsibility to notify the provider, at time of visit, that the care being received is due to a third party. I authorize premium deductions to be taken from my salary per NMSA § 10-7-5 to pay for the benefits I have elected. I understand those deductions shall be taken from my earnings on a pre-tax basis unless I submit the required POP waiver form.

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 on the mybenefits.com 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 _____