



HEALTH CARE
AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

**State of New Mexico Employees
PREMIUM ONLY PLAN (POP)
NOTICE OF WAIVER**

I, _____, wish to “waive” participation in the Premium Only Plan (POP) for the benefits plan year of January 1 through December 31, 20____.

I understand by signing this waiver, my benefits will be deducted from my pay as an after-tax deduction. I further understand that my enrollment into this program is on a yearly basis and will be up for renewal on January 1st of the coming new year and will not be automatically carried over.

Employee Name (print)

Agency Name and Number

Employee Signature

Date

Submit to EASI Gov, Inc.:

E-Mail: sonm@easitpa.com

Fax: 505-244-6009

Email: hcashb@hca.nm.gov

Late submission of the POP Waiver will not be granted.