State of New Mexico – Department of Finance and Administration

REFUND REQUEST FORM

Version 12 Rev 08.10.2020

Today's Date:	Requested By:	Telephone Number:	Pay Group:
			Choose an item.
Current PPE :	**Employee Name:**	**EMPLID#:**	**Business Unit:**
			Choose an item.

EMPLOYEE SHARE:	STATE SHARE:
Plan Type: Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $** ☐ **Taxable DP Premium**	**Plan Type:** Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $**
Plan Type: Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $** ☐ **Taxable DP Premium**	**Plan Type:** Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $**
Plan Type: Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $** ☐ **Taxable DP Premium**	**Plan Type:** Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $**
Plan Type: Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $** ☐ **Taxable DP Premium**	**Plan Type:** Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $**
Plan Type: Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $** ☐ **Taxable DP Premium**	**Plan Type:** Choose an item. **LIFE:** Choose an item. **Benefit Plan:** Choose an item. **EE Coverage:** Choose an item. **Amount: $**

Explanation for the refund: (Required)		Re-submitting ☐	
HR Manager SIGNATURE:		**DATE:**	
Print Name:		**Phone Number:**	

Required Supporting Documentation:

Please include a Summary Page showing the breakdown of the total refunds. The Summary Page must contain: a break down by pay periods impacted, what was deducted, what should have been deducted, the difference and the total by plan types (EE Share and State Share). In addition to a Summary Page please provide print screens of all pay periods that were impacted (View Paycheck -Deduction Tab) as supporting documentation. The Benefit Plan must always be the same for Employee, State and DP. Please include ERISA email as supporting documentation as well.

If the request includes prior FYs, please include agency CFO signature: ___________________________

Final Instructions: The person requesting, reviewing and approving this form cannot be recipients of the request. Requester and approver may not be the same person. Forms and supporting documentation must be submitted by 5:00 PM on Thursday Pay Period End to Central Payroll at DFA-CentralPayrollForms@state.nm.us.