

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. LPB Code	9. Hire Date	10. Job Title				
11. Effective Date	12. Reason for Change				13. Annual Salary \$	

Section B: MEDICAL		
Medical Carrier:	Medical Plan:	Coverage Tier:
<input type="checkbox"/> BCBS of New Mexico	<input type="checkbox"/> Clear Cost Platinum HMO	<input type="checkbox"/> Employee Only
<input type="checkbox"/> Presbyterian	<input type="checkbox"/> Basic Gold HMO	<input type="checkbox"/> Employee & Spouse/Domestic Partner
<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Basic Gold PPO	<input type="checkbox"/> Employee & Children
<input type="checkbox"/> Waive Medical	<input type="checkbox"/> HDHP Silver PPO	<input type="checkbox"/> Family

Section C: DENTAL		
Dental Carrier:	Dental Plan:	Coverage Tier:
<input type="checkbox"/> Delta Dental	<input type="checkbox"/> Basic PPO	<input type="checkbox"/> Employee Only
<input type="checkbox"/> MetLife Dental	<input type="checkbox"/> Buy-Up PPO	<input type="checkbox"/> Employee & Spouse/Domestic Partner
<input type="checkbox"/> Waive Dental		<input type="checkbox"/> Employee & Children
		<input type="checkbox"/> Family

Section D: VISION	Section E: DISABILITY (For Employees Only)
Vision Plan:	Disability Status:
<input type="checkbox"/> Basic	<input type="checkbox"/> Add or Continue
<input type="checkbox"/> Buy-Up	<input type="checkbox"/> Waive
<input type="checkbox"/> Waive Vision	
Coverage Tier:	
<input type="checkbox"/> Employee Only	
<input type="checkbox"/> Employee & Spouse/Domestic Partner	
<input type="checkbox"/> Employee & Children	
<input type="checkbox"/> Family	

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.nybenefitsnm.com/TermLife.html> Note: Dependent children can be added at any time. Please contact Erisa 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 Erisa Administrative Services 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.nybenefitsnm.com/Documents/HIPAA_Privacy_Notice.PDF on the nybenefitsnm.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