



Human Resources  
(575) 835-5643 Phone  
(575) 835-6963 fax

Insurance Continuation Notice

As a retiree of New Mexico Tech, you are eligible to continue your medical, dental and vision coverage.

Retiree coverage may be carried by the retiree or by their surviving spouse and dependents. The monthly cost for retiree coverage will depend on whether you elect Retiree only, 2-Party or Family coverage and also if you are eligible for Medicare.

Please indicate below whether or not you wish to continue your medical, dental and vision coverage.

Yes \_\_\_\_\_ No \_\_\_\_\_

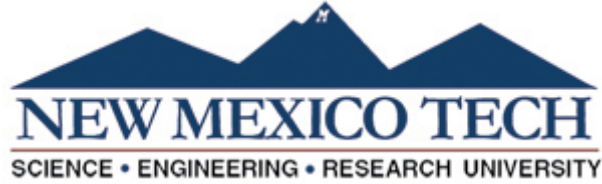
If yes, Elect Plan:

Enrollment Status \_\_\_ Retiree Only \_\_\_ 2-Party (Retiree + Spouse or Child) \_\_\_ Family (Retiree + 2 or more)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*\*Payment for this coverage must be made through either checking or savings account automatic payment. Non-payment will result in termination of coverage. Please fill out the attached authorization form for this deduction.



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### Retiree Life Insurance Election

As a retiree of New Mexico Tech, you are eligible to continue a \$10,000 life insurance policy. This policy will cost \$1.16 per month.

Please indicate below whether or not you wish to purchase this life insurance.

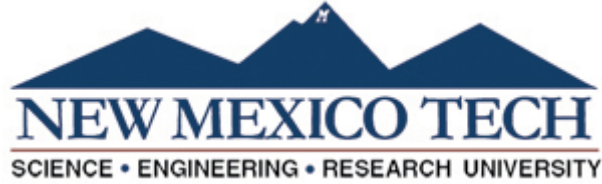
\_\_\_\_\_ Yes, I would like to purchase \$10,000 of life insurance.

\_\_\_\_\_ No, I do not wish to purchase \$10,000 of life insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*The payment for this coverage must be made through either checking or savings account automatic payment. Non-payment will result in termination of coverage. Please fill out the attached authorization form for this deduction.



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Name \_\_\_\_\_ Banner ID# \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Insurance Coverage**

**Medical**

Blue Cross Blue Shield of New Mexico  
 High Option Plan  
 Low Option Plan  
 EPO Option Plan

Cigna  
High Option  
Low Option

Presbyterian  
 High Option Plan  
 Low Option Plan

Are you eligible for Medicare  Yes  No

**Dental: Delta Dental**

High Option  Low Option Plan  Decline Dental

**Dental: United Concordia**

High Option Plan Low Option Plan Decline Dental

**Vision: Davis Vision** (2 year enrollment required)

Decline Vision

**Life - Retiree Only** \$10,000

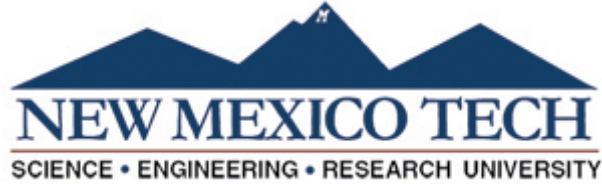
Yes  No

\_\_\_\_\_  
Spouse Date of Birth Social Security #

Dependent Children

\_\_\_\_\_  
Name Date of Birth Social Security #

\_\_\_\_\_  
Name Date of Birth Social Security #



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Authorization Agreement for Automated Payments

I (we) hereby authorize New Mexico Institute of Mining and Technology to initiate debit entries to my/our \_\_\_\_\_Checking or \_\_\_\_\_Savings account indicated below and the depository name below, hereinafter called Depository, to debit same to such account.

**Depository Information**

Name: \_\_\_\_\_  
Name of Financial Institution

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Routing # \_\_\_\_\_ Account # \_\_\_\_\_

This authority is to remain in full force and effect until New Mexico Institute of Mining and Technology and Depository has received written notification from me (or either of us) of its termination in such time and in such manner as to afford New Mexico Institute of Mining and Technology and Depository a reasonable opportunity to act on it.

Account Name: \_\_\_\_\_

Account Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach a voided check/bank form confirming routing/account number if you designate a checking account or a copy of a withdrawal slip/card if you designate a savings account.  
\*\*\*Payment for this coverage must be made through either checking or savings account automatic payment. Non-payment will result in termination of coverage.

Effective Date  
(mm/dd/yyyy)

New Mexico Public Schools Insurance Authority

District/Entity Name  
New Mexico Tech RetireesDistrict/Entity #  
407

## NM TECH RETIREE ENROLLMENT APPLICATION

Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943

<b>1</b>	Social Security Number	Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)
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Mailing Address	City	State	Zip Code	Home Phone Number
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Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Preferred E-Mail Address By furnishing my e-mail address on this form, I am consenting to receive communications related to my participation in NMPSIA's benefit program by e-mail.  <input type="checkbox"/> Check this box if you do not wish to receive plan communications by e-mail.	Work Phone Number	Cell Phone Number
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<b>2</b>	ENROLLMENT STATUS	<input type="checkbox"/> Retiree Only	<input type="checkbox"/> 2-Party (Retiree + Spouse or Child)	<input type="checkbox"/> Family (Retiree + 2 or more)
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<b>3</b>	ENROLLMENT Elect your coverage offered by New Mexico Tech
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**MEDICAL:**  Decline Medical. Reason for declining coverage: \_\_\_\_\_

<input type="checkbox"/> Blue Cross Blue Shield of NM	<input type="checkbox"/> Cigna	<input type="checkbox"/> Presbyterian
<input type="checkbox"/> High Option Plan (Default)	<input type="checkbox"/> High Option Plan (Default)	<input type="checkbox"/> High Option Plan (Default)
<input type="checkbox"/> Low Option Plan	<input type="checkbox"/> Low Option Plan	<input type="checkbox"/> Low Option Plan
<input type="checkbox"/> EPO Option Plan		

Are you eligible for Medicaid?  Yes  No

**DENTAL:**  Delta Dental  United Concordia  Decline Dental

High Option Plan (Default)  Low Option Plan  High Option Plan (Default)  Low Option Plan

**VISION: Davis Vision** (2 year enrollment required)  Decline Vision

**ADDITIONAL LIFE: The Standard** Select:  \$10,000  Decline Retiree Additional Life  
(Complete Schedule A Beneficiary Form)

<b>4</b>	<b>DEPENDENT INFORMATION</b> List all dependents you wish to enroll. Indicate an <b>A</b> (add) or <b>N/A</b> (not applicable) for all names listed below. Please provide requested information for additional dependents on separate sheet if necessary.
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Med	Dntl	Visn	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, or Court Order Attached
						<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>5</b>	<b>RETIREEEEE AUTHORIZATION STATEMENT</b>
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I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that benefits will be available subject to the exclusions, limitations and the conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for me and my dependents.

Under penalties of perjury and insurance fraud, I declare that I have examined this application and to the best of my knowledge and belief, statements are true, correct, and complete.

RETIREE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**RETURN THIS FORM TO NM TECH BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR DATE OF RETIREMENT**

<b>6</b>	<b>NEW MEXICO TECH CERTIFICATION</b>	<b>FORM MUST BE SIGNED BY NEW MEXICO TECH.</b>
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I attest that to the best of my knowledge that this applicant is a retiree of New Mexico Tech and meets the eligibility requirements for NMPSIA benefits.

Date of Retirement (mmyy/dd/yyyy)	Date of Termination of Active Coverage (mm/dd/yyyy)	Benefits Specialist Signature	Date Signed by Benefits Specialists (mm/dd/yyyy)	Date Received in Your Office
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# New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

## SCHEDULE A – BENEFICIARY ASSIGNMENT - NM TECH RETIREE

Retiree Social Security Number	Retiree Name	School District/Entity
Mailing Address:		Date of Birth (in mm/dd/yyyy format)

### Primary Beneficiary:

(For multiple beneficiaries, distribution must equal 100% for each life benefit)



Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Retiree	Address	Basic Life Percent	Additional Life Percent

(For multiple beneficiaries, distribution must equal 100% for each life benefit)



### Secondary Beneficiary (in the event the primary beneficiary is not living at the time of the insured's death):

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Retiree	Address	Basic Life Percent	Additional Life Percent

### STATEMENT OF MARITAL STATUS (check one)

- I AM NOT MARRIED. I understand that if I marry, it will affect my right to dispose of community property, and that I should then review my beneficiary designation.
- I AM MARRIED. My spouse is the Primary Beneficiary and/or is designated to receive 50% or more of my benefit.
- I AM MARRIED. My spouse is not the Primary Beneficiary and/or is designated to receive less than 50% of my benefit.

RETIREE SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

Witnessed by NM Tech: \_\_\_\_\_

DATE: \_\_\_\_\_

**IMPORTANT NOTE:** Community Property Laws are applicable to retirees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin; therefore, a spouse has property interest in insurance provided to the retiree through New Mexico Tech.

**RETURN TO NEW MEXICO TECH'S BENEFIT OFFICE**