Benefits Enrollment/Change Form for LPB

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

Section A: EMPLOYEE INFORMATION

SSN / ITIN	2. Employee (Last, First, M.I.)	3. Date of Birth	4. Sex ☐ M ☐ F	5. Marital Status ☐ Married ☐ Single

6. Mailing Address (Street)	City	County of physical residence	State	Zip

7. Home Phone	Work Phone	Cell Phone	Preferred Phone

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

Section B: MEDICAL

	Single	Employee + Sp/Partner	Employee + Child/Children	Family
☐ Waiver of Medical/Pharmacy - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Presbyterian Health Plan - HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - PPO	☐	☐	☐	☐
☐ Cigna - OAPIN	☐	☐	☐	☐
☐ Cigna - OAP	☐	☐	☐	☐

Section C: DENTAL

	Single	Employee + Sp/Partner	Employee + Child/Children	Family
☐ Waiver of Dental - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Enroll me in Dental	☐	☐	☐	☐

Section D: VISION

	Single	Employee + Sp/Partner	Employee + Child/Children	Family
☐ Waiver of Vision - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Enroll me in Vision	☐	☐	☐	☐

Section E: 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.htm
Note: Dependent children can be added at any time. Please contact Erisa to add dependent children.

Section F: DISABILITY (For Employees Only)

☐ Waiver of Disability - *An "X" in this box waives my enrollment in this benefit plan*

☐ Enroll me in Disability - Check with your HR Rep for Disability Guidelines. (Voluntary Employee Paid Election)

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

NOTE: Proof of dependency documentation, for dependents not previously covered under any benefit coverage, must be faxed to Erisa at (505) 244-6009 with the enrollment form

Indicate with an A (add), D (drop), C (continue coverage), NA (not applicable) for all names listed below.

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 Name, First Name, MI)	Sex M or F	Rel. Code 1- 6	Date of Birth
				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 toHCA Benefits in the future.
I have had the opportunity to ask questions about my benefit options and my enrollment elections 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 reviewed the information I provided in this enrollment before submitting and I confirm that the information accurately reflects my elections?
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 _____

For Employer's Payroll Deduction Authorization and Acceptance of Insurance Fraud Statement
Fax signed Enrollment/Change Form to Third Party Administrator (505-244-6009), and place a copy in employee's personnel or medical file at employer's Human Resources office.