



STATE HEALTH BENEFITS: LEAVE WITHOUT PAY (LWOP) BENEFIT PREMIUM TRANSMITTAL FORM

State Agency Name: _____ Date: _____

HR Rep: _____ Contact Phone #: _____

Employee Name: _____ Employee ID#: _____

Pay Period Ending(s): _____

HR Comments: _____

Type of leave employee is currently on:	Employee Portion Due	State Portion Due
Medical Tier		
Dental Tier		
Vision Tier		
Disability (self-pay premium)		N/A
Flexible Spending Account (FSA) Health Care		N/A
Flexible Spending Account (FSA) Dependent Care		N/A
Flexible Spending Account (FSA) Trans/Parking		N/A
Employee Supplemental Life AD&D		N/A
Dependent Life AD&D – Spouse/Domestic Partner		N/A
Dependent Life AD&D – Child(ren)		N/A
Admin Fee		
Total		
Total Amount Due (Must submit the exact amount)		

THE TOTAL AMOUNT DUE MAY BE ON ONE MONEY ORDER/CASHIER OR PERSONAL CHECK AND MADE PAYABLE TO HEALTH CARE AUTHORITY/STATE HEALTH BENEFITS. Please send payment to your HR Department.

Attention Employee: Failure to submit payment by the due date will result in retro termination and a loss of coverage.

**Attention HR: If the submitted packet is incomplete and/or incorrect, it will be rejected, and you will have to resubmit the whole packet.
When an employee is on leave of any type, the agency is responsible for the Basic Life Insurance premium(s).**

LEAVE WITHOUT PAY (LWOP/AWOL): Employees on LWOP are responsible for paying 100% of the gross premium of all elected benefit coverages in force. Premium payment is due by the Friday following the end of the pay period.

FAMILY MEDICAL LEAVE (FML): The employee is responsible for paying **the employee share** of the gross premium of all elected health benefit coverages in force. Employees on FML are given a 30-day grace period from the date on this transmittal form to make payment(s). Failure to submit payment by the due date will result in retro termination and a loss of coverage. Please refer to the Administrative Guide found at www.mybenefitsnm.com for additional guidance.

DISABILITY: Employees on Short-Term Disability must continue to pay their disability premiums to be eligible for disability benefits. If participating in primary benefits, employees are required to pay all premiums due. Once an employee has been approved and is receiving Long-Term disability benefits, disability premiums are waived.

For HR use only
Mail Payment To: HEALTH CARE AUTHORITY/STATE HEALTH BENEFITS
P.O Box 2348
Santa Fe, New Mexico 87504-2348



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

Date:

To:

Re: Personal Check Payments Policy for Self-Pay Premiums

From: Health Care Authority/State Health Benefits

If a personal check is rejected due to insufficient funds, the member will be required to pay a \$35 check return fee in addition to the amount due.

If paying by personal check I hereby acknowledge there is a \$35 check return fee assessed as a result in addition to the amount that was due.

Signed _____

Date _____

Directions to Electronically Sign: Click on Tools on the top left corner, in right window pane click Fill & Sign, Click Sign icon  in top window pane, select signature, and drag and place in desired area.

*Para asistencia en español con este formulario, por favor llame a ERISA al 1-855-618-1800