



# New Mexico Public Schools Insurance Authority



# WELCOME!

## NMPSIA 2023 Regional Training

# NMPSIA Benefits Enrollment

**Erisa Administrative Services Inc. (EASI)**

NMPSIA Employee Benefits Administration  
Erisa Administrative Services, Inc

PO Box 9054

Santa Fe NM 87504-9054

Santa Fe: (505) 988-4974 Toll Free: (800) 233-3164

Email: [sf@easitpa.com](mailto:sf@easitpa.com)

Kathy Payanes: [kpayanes@easitpa.com](mailto:kpayanes@easitpa.com)

**Contact us for assistance with:**

NMPSIA rules of enrollment and administrative practices, enrollment, eligibility, premium billing, premium collection and employer & employee online system.


# Struggles with Benefits Enrollment

**Kathy Payanes, Erisa**

What's wrong  
with this?



Example 2



**New Mexico Public Schools Insurance Authority**  
Erisa Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3154 or (505) 683-4974 • Fax: (505) 686-8043

**SCHEDULE A – BENEFICIARY ASSIGNMENT**

<small>Employee Social Security Number</small> [REDACTED]	<small>Employee Name</small> [REDACTED]	<small>School District/Employer</small> [REDACTED]
<small>Mailing Address</small> [REDACTED]		<small>Date of Birth (in month/day format)</small> [REDACTED]

**Primary Beneficiary:** (If or if more beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in month/day format)	Relationship to the Employee	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 month/day format)	Relationship to the Employee	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.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

Witnessed by Employer: \_\_\_\_\_ DATE: \_\_\_\_\_

**IMPORTANT NOTE:** Community Property Laws are applicable to employees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin, therefore, a spouse has property interest in insurance provided to the employee through his/her employment.

**RETURN TO YOUR EMPLOYER'S BENEFIT OFFICE**

10/10/2014

Example 3

No. 50711

# MARRIAGE LICENSE

STATE OF ~~NEW MEXICO~~ COUNTY OF [REDACTED]

*To our persons Authorized & lawfully perform the Marriage Ceremony*

## GREETINGS

YOU ARE HEREBY AUTHORIZED TO JOIN IN MARRIAGE

[REDACTED] [REDACTED] New Mexico  
 and [REDACTED] [REDACTED] New Mexico

and that this license you will make use of within the time period prescribed by law.

WITNESS my hand and seal of said Court in Law at [REDACTED] New Mexico  
 this [REDACTED] day of [REDACTED] 1996

By [REDACTED] Deputy [REDACTED] County Clerk

Received [REDACTED] 1996 at [REDACTED] A.M. [REDACTED] Page No. [REDACTED]


By [REDACTED] Deputy [REDACTED] County Clerk







**Example 6**

Employer Unit: <input type="checkbox"/> VOLUNTARY <input type="checkbox"/> FUNCTIONAL		MEDICAL: \$ <input type="checkbox"/>	DENTAL: \$ <input type="checkbox"/>	VISION: \$ <input type="checkbox"/>	DISABILITY: \$ <input type="checkbox"/>	ADDITIONAL LIFE: \$ <input type="checkbox"/>	Former Employer (if covered under MSP/A): <input type="checkbox"/>	Basic Life Eff. Date (mm/dd/yyyy): <u>07-01-2023</u>	Other Cvg. Eff. Date (mm/dd/yyyy): <u>07-01-2023</u>
 <b>New Mexico Public Schools Insurance Authority</b> 1.1.2021 EMPLOYEE ENROLLMENT APPLICATION Eligibility Administrative Office (505) 868-4874 / (800) 233-3164 FAX (505) 868-8943		Organization Name: [REDACTED]		District/County #: [REDACTED]					
<b>1</b> Social Security Number: [REDACTED]		Name (Last, First, Middle): [REDACTED]				Date of Birth (mm/dd/yyyy): [REDACTED]			
Mailing Address: [REDACTED]		City: [REDACTED]		State: [REDACTED]		Zip Code: [REDACTED]		Home Phone Number: [REDACTED]	
Marital Status: <input checked="" type="checkbox"/> S <input type="checkbox"/> M		Gender: <input checked="" type="checkbox"/> F <input type="checkbox"/> M		Preferred E-Mail Address: [REDACTED]		Work Phone Number: [REDACTED]		Cell Phone Number: [REDACTED]	
<input checked="" type="checkbox"/> Check this box if you do not wish to receive plan communications by e-mail									
<b>2</b> ENROLLMENT STATUS: <input checked="" type="checkbox"/> Employee Only		<input type="checkbox"/> 2-Party (Employee + Spouse or Child)		<input type="checkbox"/> Family (Employee + 2 or more)					
<b>3</b> ENROLLMENT: Elect your coverage offered by your employer		<input checked="" type="checkbox"/> <b>BASIC LIFE:</b> The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form)							
<b>MEDICAL:</b> <input checked="" type="checkbox"/> Blue Cross Blue Shield of NM									
<input checked="" type="checkbox"/> High Option Plan (Default)		<input type="checkbox"/> High Option Plan (Voluntary)		<input type="checkbox"/> High Option Plan (State of NM)		<input type="checkbox"/> High Option Plan (State of NM)		<input type="checkbox"/> Second Medical: Necessary for seeking coverage	
<input type="checkbox"/> Low Option Plan		<input type="checkbox"/> Low Option Plan		<input type="checkbox"/> Low Option Plan		<input type="checkbox"/> Low Option Plan		Are you eligible for Medicaid? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<input type="checkbox"/> EP D Option Plan									
<b>DENTAL:</b> <input type="checkbox"/> Delta Dental		<input checked="" type="checkbox"/> High Option Plan (Default)		<input type="checkbox"/> Low Option Plan		<input type="checkbox"/> United Healthcare		<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"/> Low Option Plan		<input type="checkbox"/> Directly Linked	
<input checked="" type="checkbox"/> <b>VISION:</b> Delta Vision (2 year enrollment required)		<input type="checkbox"/> Delta Vision		<input type="checkbox"/> Delta Vision		<input type="checkbox"/> Delta Vision		<input type="checkbox"/> Delta Vision	
<input type="checkbox"/> <b>LONG TERM DISABILITY:</b> The Standard		<input type="checkbox"/> Long Term Disability		<input type="checkbox"/> Long Term Disability		<input type="checkbox"/> Long Term Disability		<input checked="" type="checkbox"/> Decline Long Term Disability	
<input type="checkbox"/> <b>ADDITIONAL LIFE:</b> The Standard		<input type="checkbox"/> Spouse/Child		<input type="checkbox"/> Spouse/Child		<input type="checkbox"/> Spouse/Child		<input checked="" type="checkbox"/> Decline Employee Additional Life	
<input type="checkbox"/> Decline Employee Additional Life		<input type="checkbox"/> Decline Dependent Life		<input type="checkbox"/> Decline Dependent Life		<input type="checkbox"/> Decline Dependent Life		<input type="checkbox"/> Decline Dependent Life	
<input type="checkbox"/> Decline Dependent Life									
<b>4</b> DEPENDENT INFORMATION: List all dependents you wish to enroll. Indicate an A (adult) or N/A (not applicable) for all names listed below.		Please provide relevant information for additional dependents on separate sheets if necessary.							
First Name	Last Name	Date of Birth (mm/dd/yyyy)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	Dependent's Relationship to You:	Proof of Marriage, Birth, or Court Order Attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b> EMPLOYEE AUTHORIZATION STATEMENT									
I hereby authorize my school district/employer to deduct from my earnings and further within stated amounts back to it a contribution required of me toward the plan(s) which employer. I hereby apply to the Authority for the coverage offered to myself and dependent(s) when done. I understand that services will be available subject to the enrollment, premium and the conditions described in the General Group Insurance Plan(s) and/or any related, attached, or other health care provider to which I have applied to the insurance carrier such medical coverage as I may require for myself and my dependent(s). I authorize the insurance carrier to coordinate with the employer's health plan or insurance companies. Under penalties of perjury and the law, I declare that I have read this application and supporting documentation, and to the best of my knowledge and belief, they are true, correct, and complete. Read reverse side before signing.									
EMPLOYEE SIGNATURE: [REDACTED]						DATE: <u>5/17/2023</u>			
<b>RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE: NO LATER THAN 31 DAYS FROM YOUR DATE OF HIRE.</b>									
<b>6</b> EMPLOYER CERTIFICATION: ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY EMPLOYER.									
I affirm that to the best of my knowledge that the applicant is an employee of my district/county (check one) and that the minimum number of hours per week required to qualify for coverage is:									
Date of Hire:	Base Annual Salary:	# of hours worked weekly:	Job Title:	<input type="checkbox"/> Check only if Variable Hour Employee	Last Date Variable Hour Employee became eligible for medical only coverage:	Date Received in Your Office:			
<u>3/28/23</u>	<u>\$34,408</u>	<u>40</u>	<u>Recenter</u>	<input type="checkbox"/>		<u>MAY 18 2023</u>			
BENEFITS SPECIALIST SIGNATURE: [REDACTED]						DATE: <u>05/18/2023</u>			
Revised September 2020									

**Example 7**

**New Mexico Public Schools Insurance Authority**  
**EMPLOYEE CHANGE CARD**  
Eligibility Administrative Office: (505) 388-4974 (800) 233-3164 FAX (505) 986-8943

**1 Social Security Number** [Redacted] **Name (Last, First, Middle)** [Redacted] **Date of Birth** [Redacted]

**Mailing Address** [Redacted] **City** [Redacted] **State** [Redacted] **Zip Code** [Redacted] **Home Phone Number** [Redacted]

**Marital Status**  S  M  F  M **Gender**  F  M **E-Mail Address Required** [Redacted] **Work Phone Number** [Redacted] **Cell Phone Number** [Redacted]

**REASON FOR CHANGE**  
 Late Enrollment  New address and/or phone number  
 Open/Switch Enrollment  Qualifying Event  
 Answer questions below: What event took place? **Divorce**  
 What date did event take place? **05/09/2023**

**2 ENROLLMENT**  
 What is your current enrollment status?  
 Employee Only  Employee Only  Spouse or Child  Family (Employee + 2 or more)  
 Open/Switch Enrollment  Employee Only  Spouse or Child  Family (Employee + 2 or more)  
 Check One:  ADD COVERAGE  CANCEL COVERAGE  SWITCH ENROLLMENT

**MEDICAL**  
 Blue Cross Blue Shield of NM  Cigna  Prudential  Decline Medical  
 High Option (Default)  High Option (Default)  High Option (Default)  High Option (Default)  
 Low Option  Low Option (Default)  Low Option  Low Option  
 EPO/Other  Other (Specify Plan)  Other (Specify Plan)  Other (Specify Plan)  
 Existing: **TRICARE**  
 Eligible for Medicaid?  Yes  No

**DENTAL** Delta Dental:  High Option (Default)  Low Option  United Concordia  High Option (Default)  Low Option  Decline Dental

**VISION** Davis Vision (7 year enrollment required)  Decline Vision

**LONG TERM DISABILITY** The Standard (Long-term disability coverage)  Decline Long Term Disability

**ADDITIONAL LIFE** The Standard **Select:**  1X  2X  3X Base Annual Salary  Decline Employee Additional Life  
 Spouse Life  Child Life  Decline Dependent Life

**3 DEPENDENT INFORMATION** List all dependents you wish to enroll. Provide requested information for additional dependents on separate sheet if necessary. Indicate as A (add), D (drop), C (continues coverage), or N/A (not applicable) for all names listed below.

Med	Child	Vision	Add Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Eligible for Coverage (Yes/No) (Other/None)
							<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

**4 EMPLOYEE AUTHORIZATION STATEMENT**  
 I hereby authorize my school district to permit the [Redacted] to be added to the [Redacted] plan. I understand that services will be available subject to the exclusions, limitations and restrictions described in the Medical Group Insurance Policies. I authorize any hospital, physician or other health care provider to send information to the [Redacted] Center for medical information as it may require for myself and my dependents. I authorize the [Redacted] Center to use this information for the purposes of providing services to me and my dependents. I understand that the [Redacted] Center will not release this information to any other party without my written consent. I have read and understand the application and supporting documentation, and I have signed it.

**EMPLOYEE SIGNATURE** [Redacted] **DATE** 05/09/2023

**RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR QUALIFYING EVENT**

**5 EMPLOYER CERTIFICATION** ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY EMPLOYER.  
 I affirm that to the best of my knowledge that this applicant is an employee of my district/county for nearly the entire calendar year and works the minimum number of hours per week required for NMPSIA benefits.

Date of Hire	Base Annual Salary	# of hours worked weekly	JOB Title	<input type="checkbox"/> Check only if Variable Hour Employee	Last date Variable Hour Employee became eligible for medical only coverage	Date Received in Your Office
\$						

**BENEFITS SPECIALIST SIGNATURE:** [Redacted] **DATE:** [Redacted]

Revised March 2022



**Example 9**

**Example 9**

20312869  
New Mexico Public Schools Insurance Authority  
**EMPLOYEE ENROLLMENT APPLICATION**  
Highway Administration Office (505) 988-6974 (800) 233-3164 FAX (505) 985-1843

1 Social Security Number [REDACTED] Name (Last, First, Middle) [REDACTED] Date of Birth (mm/dd/yyyy) [REDACTED]

2 ENROLLMENT STATUS  Employee Only  Party (if Employee is Spouse or Child)  Family (Employee 1-2 Children)

3 ENROLLMENT (Select your coverage offered by your employer)  
 BASIC LIFE (One Standard Death or 100 by beneficiary. Transferable to Spouse & Beneficiary Spouse)  
 MEDICAL:  Blue Cross Blue Shield of NM  High Option Plan (Default)  Low Option Plan  PPO Option Plan  
 Vision: Daily Vision (2 year commitment may apply)  Dental:  Health Savings Plan (Default)  Health Reimbursement Arrangement  Flexible Spending Account  
 ADDITIONAL LIFE (One Standard)  One Life  Two Life  Three Life  Four Life  Five Life  Six Life  Seven Life  Eight Life  Nine Life  Ten Life  Unlimited Employee Additional Life  Unlimited Spouse/Child Life

4 DEPENDENT INFORMATION (I will list up to 14 persons in total. Indicate an A (Adult) or CHA (Child) for all persons listed below. Please complete this section for all dependents who are eligible for enrollment.)

First Name	Last Name	Relationship	Age	Sex	Marital Status	Employment Status	Order of Marriage
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]


5 EMPLOYEE AUTHORIZATION STATEMENT  
I hereby authorize my employer to deduct from my earnings and deposit into a trust account for my benefit the amount of my health insurance premium. I hereby agree to the Authority for the benefits offered to myself and dependent spouse above. I understand that coverage will be available subject to the conditions, limitations and the conditions described in the Member's Insurance Policies. I authorize any medical, physical or other health care services or health care products to be provided to me and my dependent spouse and medical information to be shared with my employer. I will work for the Insurance Center to coordinate benefits and/or reimbursements and other health care services for my family. Under benefits of family and I warrant that I have examined the policies and supporting documentation, and to the best of my knowledge and belief, I agree that, correct, and complete. Please reverse side before signing.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR DATE OF HIRE**


6 EMPLOYER CERTIFICATION (All information in this section is required to be completed by the employer. PLEASE COMPLETE THIS SECTION THOROUGHLY. Your input is required for this section.)  
 I certify that to the best of my knowledge and belief, the applicant is an employee who is eligible to enroll in the employee benefit plan and is not currently enrolled in another employer's benefit plan.  
 Date of Hire: 8/31/22 Base Annual Salary: \$28,000 # of Hours worked Weekly: 33.75 Job Title: Bus Driver  
 Otherwise I Certify that Employee became eligible for medical/benefits coverage  
 Date Placed in Your Office: \_\_\_\_\_  
 BENEFITS SPECIALIST SIGNATURE [REDACTED] DATE 5/3/23  
 Revised March 2022

**Example 10**

Payroll Deductions: MEDICAL \$ _____ DENTAL \$ _____ VISION \$ _____ DISABILITY \$ _____ ADDITIONAL LIFE \$ _____					Former Employer (if covered under NMPISA)		Basic Life Bk Date (mm/yyyy)		Other Cng Bk Date (mm/yyyy)		
 <p><b>New Mexico Public Schools Insurance Authority</b>  <b>NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY</b>          Eligibility Administrative Office (505) 269-1974 (800) 232-3164 FAX (505) 268-8943</p>											
1 Social Security Number			Name (Last, First, Middle)					Date of Birth			
Mailing Address				City		State	Zip Code	Home Phone Number			
Marital Status	Gender	E-Mail Address (Required)				Work Phone Number		Cell Phone Number			
<input type="checkbox"/> S	<input checked="" type="checkbox"/> M	<input type="checkbox"/> F	<input checked="" type="checkbox"/> M								
REASON FOR CHANGE:					Answer questions below						
<input type="checkbox"/> Late Enrollment					<input type="checkbox"/> New address and/or phone number						
<input type="checkbox"/> Open/Switch Enrollment					<input checked="" type="checkbox"/> Qualifying Event						
					What event took place? <b>SPOUSE NEW EMPLOYMENT</b>						
					What date did event take place? <b>05/22/23</b>						
2 ENROLLMENT											
What is your highest enrollment status?											
<input type="checkbox"/> Single (Employee)	<input type="checkbox"/> Spouse of (Employee)	<input type="checkbox"/> Family (Employee + 1 or more)	<input checked="" type="checkbox"/> Family (Employee + 2 or more)	<input type="checkbox"/> Family (Employee + 3 or more)	<input type="checkbox"/> Family (Employee + 4 or more)	<input type="checkbox"/> Family (Employee + 5 or more)	<input type="checkbox"/> Family (Employee + 6 or more)	<input type="checkbox"/> Family (Employee + 7 or more)	<input type="checkbox"/> Family (Employee + 8 or more)	<input type="checkbox"/> Family (Employee + 9 or more)	
<input type="checkbox"/> Single (Spouse of Employee)	<input checked="" type="checkbox"/> Part, (Employee + Spouse of Employee)	<input type="checkbox"/> Family (Employee + 1 or more)	<input type="checkbox"/> Family (Employee + 2 or more)	<input type="checkbox"/> Family (Employee + 3 or more)	<input type="checkbox"/> Family (Employee + 4 or more)	<input type="checkbox"/> Family (Employee + 5 or more)	<input type="checkbox"/> Family (Employee + 6 or more)	<input type="checkbox"/> Family (Employee + 7 or more)	<input type="checkbox"/> Family (Employee + 8 or more)	<input type="checkbox"/> Family (Employee + 9 or more)	
MEDICAL: <input type="checkbox"/> Cross Blue Shield of NM (High Option/Default) <input type="checkbox"/> Cross Blue Shield of NM (Low Option) <input type="checkbox"/> Cigna (High Option/Default) <input type="checkbox"/> Cigna (Low Option/Default) <input checked="" type="checkbox"/> Presbyterian (High Option/Default) <input type="checkbox"/> Presbyterian (Low Option/Default) <input type="checkbox"/> Online (Special)											
DENTAL: (Data Dental) <input checked="" type="checkbox"/> High Option/Default <input type="checkbox"/> Low Option/Default <input type="checkbox"/> Valed Concordia <input type="checkbox"/> High Option/Default <input type="checkbox"/> Low Option/Default <input type="checkbox"/> Decline Dental											
VISION: (Data Vision) <input checked="" type="checkbox"/> High Option/Default <input type="checkbox"/> Low Option/Default <input type="checkbox"/> Decline Vision											
LONG TERM DISABILITY: The Standard (qualifying event or occurrence necessary) <input type="checkbox"/> Decline Long Term Disability											
ADDITIONAL LIFE: The Standard (qualifying event or occurrence necessary) <input type="checkbox"/> Spouse Life <input type="checkbox"/> Child Life <input type="checkbox"/> Decline Employee Additional Life <input type="checkbox"/> Decline Dependents Life											
3 DEPENDENT INFORMATION (List all dependents you wish to enroll. Provide requested information for additional dependents on separate sheets if applicable. Indicate an A (add), D (drop), C (continue coverage), or NA (not applicable) for all names listed below.)											
Med	Dent	Vsn	Add/Drop	Dependent's Name (Last, First, Middle)			Social Security Number (REQUIRED)	Date of Birth (mm/yyyy)	Gender	Dependent's Relationship to You	Married (Yes/No) or Civil Union (Yes/No)
D	D	D	N/A	[REDACTED]			[REDACTED]	[REDACTED]	F	M	SPOUSE <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
C	C	C	N/A	[REDACTED]			[REDACTED]	[REDACTED]	F	M	DAUGHTER <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
											<input type="checkbox"/> Yes <input type="checkbox"/> No
											<input type="checkbox"/> Yes <input type="checkbox"/> No
4 EMPLOYEE AUTHORIZATION STATEMENT											
I hereby authorize my school district/employer to deduct from my earnings all health care expenses equal to the cost of my medical and dependent health care. I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that services will be available subject to the exclusions, limitations and the copayments described in the Master Group Insurance Plan and will have any hospital, attention or other health care provider to furnish when required to the Insurance Center such medical information as may require for need and my dependents. I acknowledge the Insurance Center to coordinate benefits and/or reimbursements with other health plans or multiple companies. Under penalty of perjury and under oath, I declare that I have read this application and supporting documentation, and to the best of my knowledge and belief, this application is complete. Read reverse side before signing.											
EMPLOYEE SIGNATURE: [REDACTED]										DATE: 05/22/23	
RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR QUALIFYING EVENT.											
5 EMPLOYER CERTIFICATION											
ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY EMPLOYER.											
I attest that to the best of my knowledge that this applicant is an employee of my district/entity (or meets the one-business definition) and works the minimum number of hours per week required for NMPISA benefits.											
Date of Hire	Base Annual Salary	# of hours worked weekly	Job Title	<input type="checkbox"/> Check only if Variable Hour Employee	Last date Variable Hour Employee became eligible for medical only coverage	Date Received in Your Office					
	\$										
BENEFITS SPECIALIST SIGNATURE: [REDACTED]										DATE: 05/22/23	

**Example 11**

**ConocoPhillips (d/o Businessolver, Inc.)**  
P.O. Box 770  
Monroe, WI 53566-0770  
**DO NOT MAIL CORRESPONDENCE OR PAYMENTS TO THIS ADDRESS**



Kelli Hammond and Family  
2502 S Haldeman  
Artesia, NJ 88210

Notice Date: April 27, 2023  
Prepared For: Kelli Hammond and Family

**COBRA Continuation Coverage & Other Health Coverage Alternatives**

You're getting this notice because you recently lost coverage under ConocoPhillips group health plan ("the Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Please read the information in this notice very carefully before you make your decision.

This notice has important information about your right to continue your health care coverage under the Plan, as well as other health coverage options that may be available to you including coverage through the Health Insurance Marketplace. To sign up for Marketplace coverage, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 (TTY: 1-455-489-4325). You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. People in most states use [www.HealthCare.gov](http://www.HealthCare.gov) to apply for and enroll in health coverage. If your state has its own Marketplace platform, you can find contact information here: [www.HealthCare.gov/marketplace-in-your-state](http://www.HealthCare.gov/marketplace-in-your-state).

Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should enroll online at [mybenefits.conocophillips.com](http://mybenefits.conocophillips.com) or use the Election Form provided later in this notice.

**Enrolling in COBRA Online Is Easy & Secure**

1. **Go to [mybenefits.conocophillips.com](http://mybenefits.conocophillips.com)** and log in with your username and password. If you don't know them, you may reset your username and password or **Register** as a first-time user. Your Company Key is **conocophillips**.
2. **Review and make your COBRA elections.** The online enrollment process makes it easy to select the coverage you're eligible for. Click "Start Here" to begin your enrollment.
3. **Choose the payment method you want.**
  - a. **Pay Online** – Provide your bank account information. You can set up automatic monthly payments and avoid the usual \$2.00 monthly convenience fee.
  - b. **Pay by Check** – Make your check payable to **ConocoPhillips**.

Mail checks and correspondence to this address only:

**ConocoPhillips (d/o Businessolver, Inc.)**  
PO BOX 850512  
MINNEAPOLIS, MN 55485-0512

If you have any questions regarding your benefits or this notice, please login to [mybenefits.conocophillips.com](http://mybenefits.conocophillips.com).

**Deadline to Enroll in COBRA**  
Your elections must be completed and/or postmarked no later than  
**06/29/2023**

Your active coverage ends on **04/30/2023**  
If elected, COBRA coverage will be effective on **03/01/2023**


*If you are electing COBRA as a dependent of a former employee who is not also electing COBRA or due to dependent qualifying event (such as a divorce or child reaching maximum age), you cannot enroll online. You will need to return the paper election form found in this package. Once enrolled, you will be able to login to [mybenefits.conocophillips.com](http://mybenefits.conocophillips.com) and create your online account.*

Coverage provided by ConocoPhillips to you and/or your covered dependent(s) ends on 04/30/2023 due to the following qualifying event: Divorce. You have the right to elect COBRA continuation coverage for a duration of up to 36 months.

Only members covered at the time of Qualifying Event are eligible for continuation. The following Qualified Beneficiaries are eligible to continue coverage under COBRA:

Kelli Hammond



283949300

**Example 12**

LifePoint Benefits Service Center  
2322 W. Grand Parkway N. Suite 100  
Katy, TX 77449

**CERTIFICATE OF GROUP HEALTH PLAN COVERAGE**

**IMPORTANT - KEEP THIS CERTIFICATE.** This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

**Preexisting Condition Exclusions.** Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break. Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

**Right to get special enrollment in another plan.** Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.) Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request enrollment as soon as possible.

**Prohibition against discrimination based on a health factor.** Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

**Right to individual health coverage.** Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job. Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible status due to a 63-day break.

TERMINATED  
MAY 11 2023  
EASI

MAY 10 2023



**Example 13**

NMPSIA  
2011-05-30 17:40:21  
 This information should be on employer letterhead and signed by the employer representative with verifiable address and phone information.

**Where**

Employer Name  
Address  
Telephone Number

Loss of Coverage Notice

To NMPSIA Employer Group:

**Who** Lost the Coverage:      **What Kind of Coverage was Lost:**      **When** Last Day of Coverage:

_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	_____

**Why** was the Coverage Lost:

Retirement     Resignation     Termination of Employment

Reduction in Hours Worked     Ineligible due to \_\_\_\_\_ (Divorce, Death, Age, etc.)

Sincerely,

Employer Signature

[https://nmpsia.com/pdfs/Sample\\_Loss\\_of\\_Coverage\\_Notice\\_Form.pdf](https://nmpsia.com/pdfs/Sample_Loss_of_Coverage_Notice_Form.pdf)

# Tip

Before you sign and date a NMPSIA form, scan from top to bottom to ensure that each section is completed, readable and verifiable.

# Break & Group Stretch

## 10:00 – 10:15

### Coming up:

- 10:15 a.m. CCMSI - Jerry Mayo and Vanessa Devine**
- Introduction of Jessica Sanchez, NMWCA
  - Struggles with Workers' Compensation Reporting
- 11:30 a.m. Why Wellness? – NMPSIA Wellness Team**

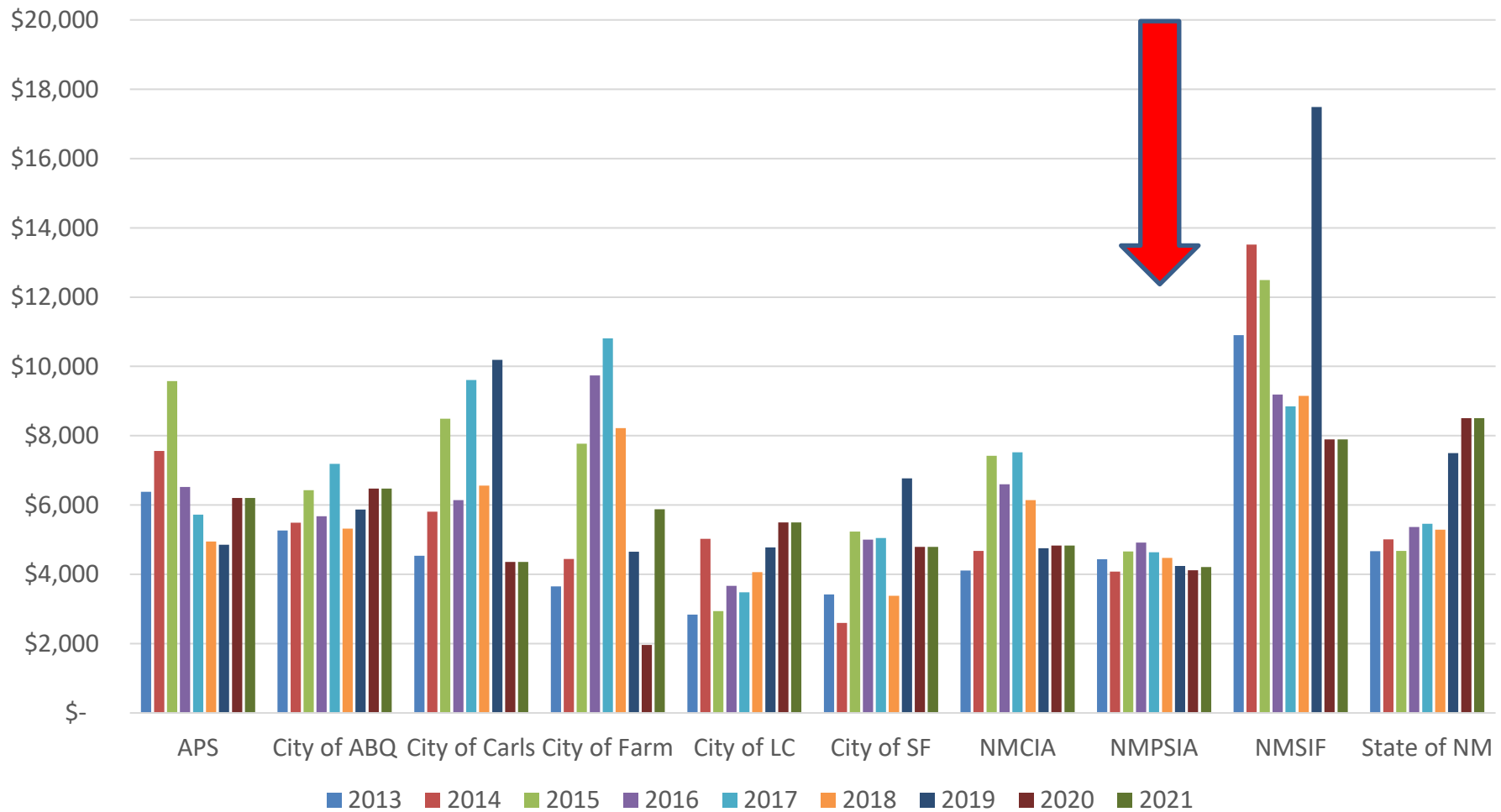
# CCMSI

## Workers Compensation

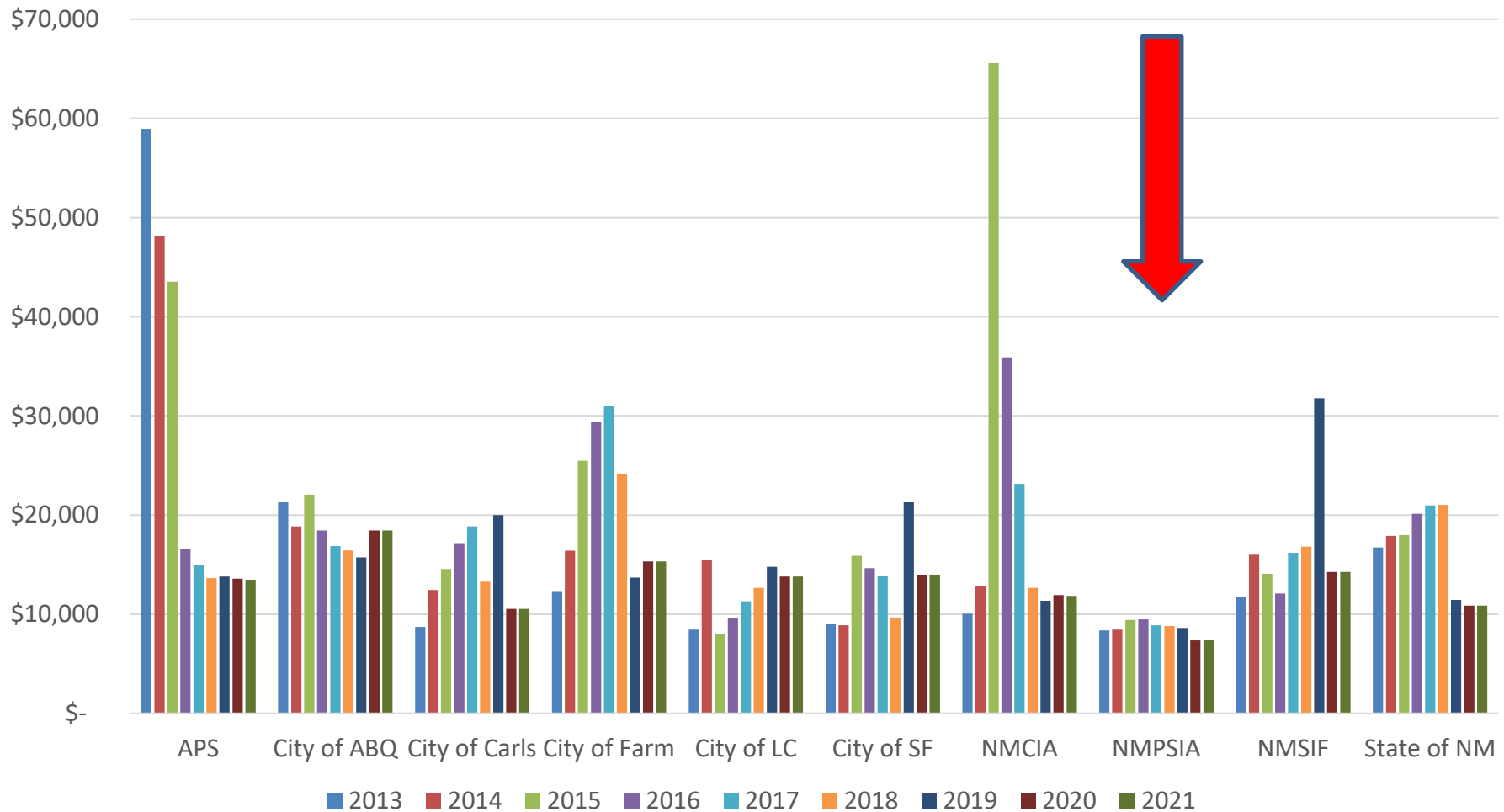
Jerry Mayo & Vanessa  
Devine

# THANK YOU!

# State of New Mexico Comparison Average Cost per Claim



# State of New Mexico Comparison Average Cost per Indemnity Claim



# Workers' Compensation

Employers are required to post the workers' compensation poster with the Notice of Accident (NOA) forms at their workplace. The NOA forms are to be attached or adjacent to the poster.

Printable forms located at:

<https://workerscomp.nm.gov/NMWCA-Publications>

Or you can call 1-866-967-5667 to request copies.

State of New Mexico Workers' Compensation Administration

## WORKERS' COMPENSATION ACT

If You Are Injured At Work

Si Se Lastima En El Trabajo

**1) Notice** – In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

**2) You have the right** to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

**3) Claims information** – Contact your employer's Claims Representative (see box below).

**1) Aviso** – En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

**2) Usted tiene el derecho** a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

**3) Información acerca de Reclamaciones** – Contactese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

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

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Note: Employer must fill in insurer / claim representative information

**YOUR RIGHTS**

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than seven days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

**SUS DERECHOS**

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es el que selecciona primero, póngaselo o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un período de tiempo más largo.

Our offices are located at the following offices:

Albuquerque: 1-866-967-5667	Farmington: 1-800-518-7318	Tulsa: 1-800-614-3456	Las Cruces: 1-800-678-6826	Las Vegas: 1-800-231-7889	Alamogordo: 1-866-311-8897	Santa Fe: 1-865-476-7348
1-818-841-6998	1-895-599-9746	1-575-397-3425	1-575-524-6246	1-505-454-9251	1-575-424-3997	

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1-866-WORKOMP (1-866-967-5667)

Visit our website at: <https://workerscomp.nm.gov>

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

**EMPLOYER:** You are required by law to display this poster where your employees can read it. Post the Notice of Accident forms with it. The poster without the Notice of Accident forms does not comply with law. You have other rights and duties under the law.

New Mexico Workers' Compensation Administration  
2400 Central Avenue, Albuquerque, New Mexico 87104  
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

POST FORMS HERE



Name: CCMSI  
Phone #: 800-635-0679 505-837-8700  
Address: P.O. Box 30870  
Albuquerque, New Mexico 87190-0870

**Employer's Insurer / Claims Representative:**

**Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Note: Employer must fill in insurer / claims representative information.**

**OHMS**  
OCCUPATIONAL  
HEALTHCARE  
MANAGEMENT  
SERVICES

RELEASE OF MEDICAL INFORMATION

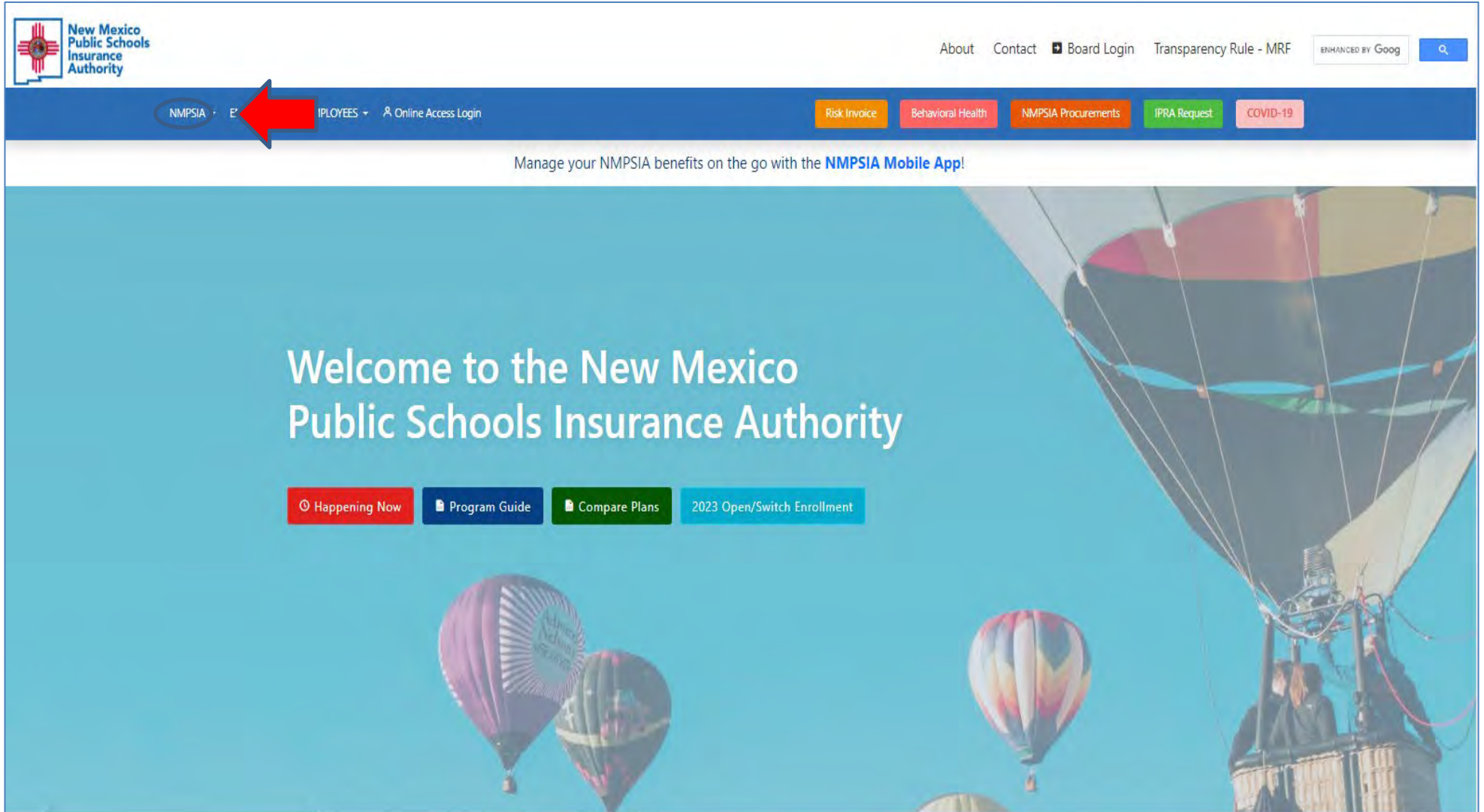
**Be sure you are using the most current forms from the NMPSIA website!**

We are still finding schools that are using forms from OHMS (Occupational Health Management Services). They were the claims administrator prior to CCMSI but they have not managed the claims since 2002!

We also recently received a Notice of Accident (NOA) form that was from 1999!

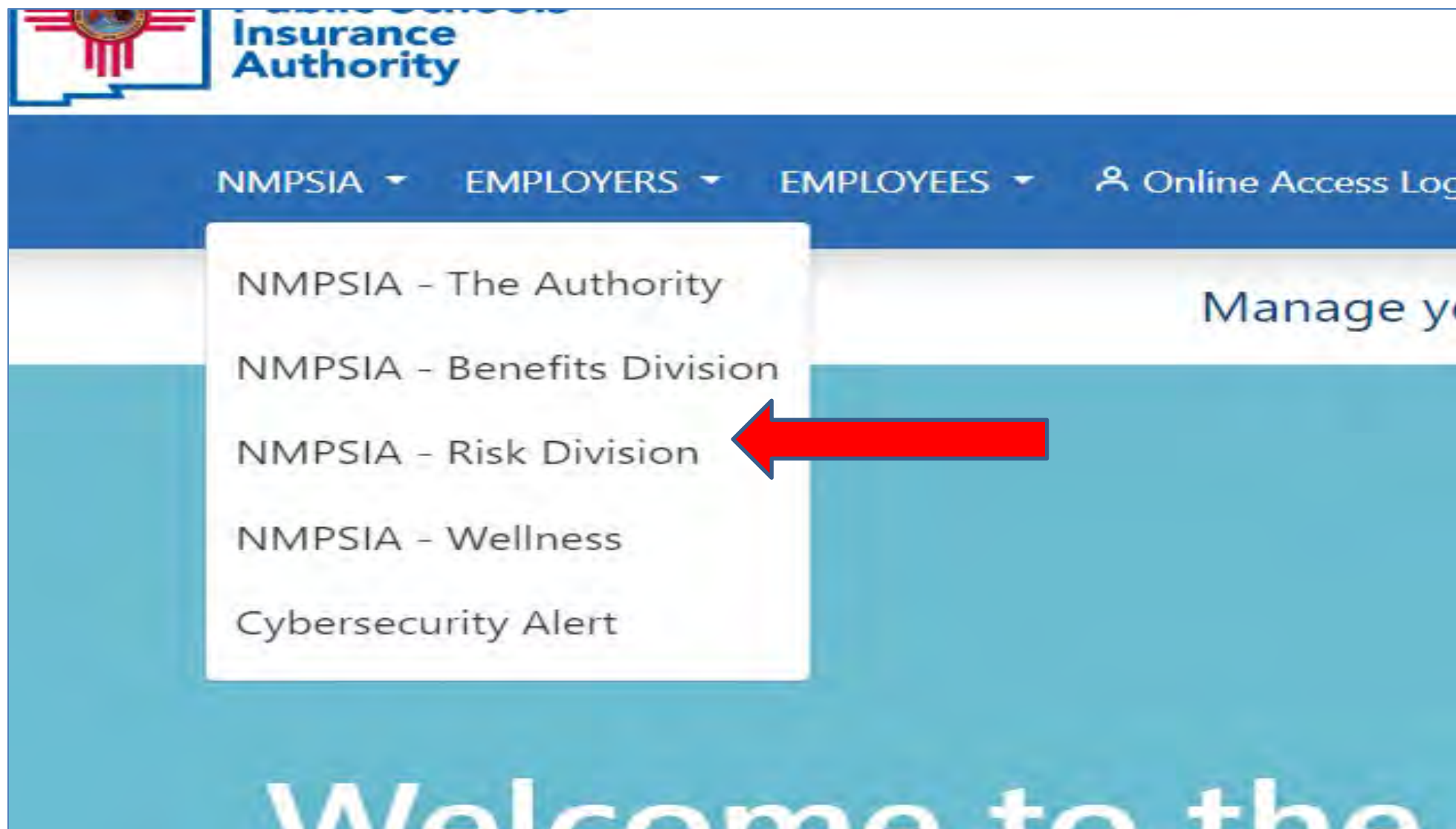
**Please use the forms from the NMPSIA website!**

# Workers' Compensation



The screenshot shows the homepage of the New Mexico Public Schools Insurance Authority. At the top left is the organization's logo. The top right contains navigation links: "About", "Contact", "Board Login", and "Transparency Rule - MRF", along with a search bar labeled "ENHANCED BY Google". A dark blue navigation bar below the header contains the following items: "NMPSIA" (circled in red with a red arrow pointing to it), "EMPLOYEES" (with a dropdown arrow), and "Online Access Login" (with a magnifying glass icon). To the right of these are five colored buttons: "Risk Invoice" (orange), "Behavioral Health" (red), "NMPSIA Procurements" (orange), "IPRA Request" (green), and "COVID-19" (pink). Below the navigation bar is a white banner with the text "Manage your NMPSIA benefits on the go with the [NMPSIA Mobile App!](#)". The main content area features a large blue background with a hot air balloon image on the right. The text "Welcome to the New Mexico Public Schools Insurance Authority" is centered in white. Below this text are four buttons: "Happening Now" (red), "Program Guide" (dark blue), "Compare Plans" (green), and "2023 Open/Switch Enrollment" (light blue).

## Workers' Compensation



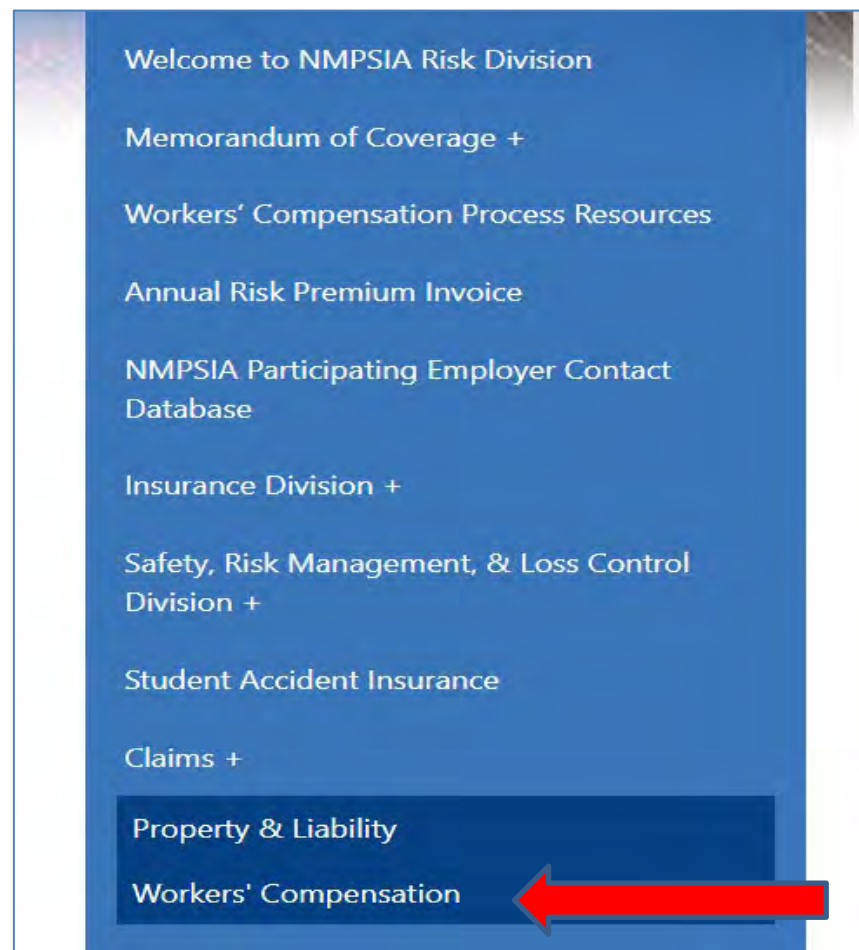
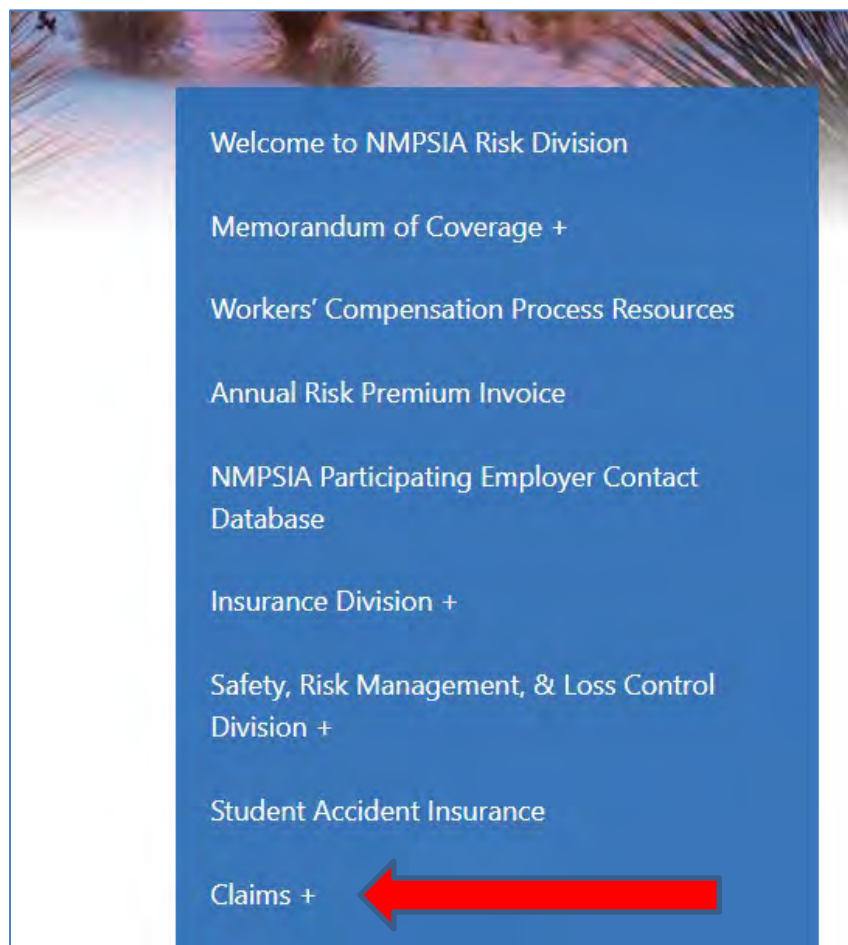
The screenshot shows the website's navigation menu. The top navigation bar includes "NMPSIA", "EMPLOYERS", "EMPLOYEES", and "Online Access Log". A dropdown menu is open under "NMPSIA", listing several options. A red arrow points to the "NMPSIA - Risk Division" option.

- NMPSIA - The Authority
- NMPSIA - Benefits Division
- NMPSIA - Risk Division
- NMPSIA - Wellness
- Cybersecurity Alert

Manage yo

Welcome to the


# Workers' Compensation



# Workers' Compensation

## Workers' Compensation Forms & Documents

### Forms

- Notice of Accident or Occupational Disease 
- Alternative Notice of Accident (NOA-2 Employee's Choice)
- Employers' First Report of Injury or Illness
- Supervisor's Accident Investigation Report
- Report of Work Ability

Sample Workers' Compensation Policy Options

# Workers' Compensation NOA

## NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11  
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29, Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, \_\_\_\_\_, was involved in an on-the-job accident or was disabled  
Yo, (name of employee/nombre del empleado) me lastimé en un accidente en el trabajo o fui incapacitado

by an occupational disease at approximately \_\_\_\_\_, on \_\_\_\_\_, 20\_\_\_\_\_  
por enfermedad de oficio aproximadamente (time/a la(s) hora(s)) el (date/fecha) del 20\_\_\_\_\_.

Employee's social security number: \_\_\_\_\_ Where did the accident occur? \_\_\_\_\_  
Número de seguro social del empleado: ¿Dónde ocurrió el accidente?

What happened? \_\_\_\_\_  
¿Qué ocurrió?

**To be completed by Employer:**

Completado por el empleador.

**If Yes, Employer has right to change health care provider after 60 days.**  
En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 días.

**WORKER'S INITIALS \_\_\_\_\_ INICIALES DEL TRABAJADOR**

**Worker will choose health care provider. Yes \_\_\_ No \_\_\_**

Trabajador elegirá proveedor de atención médica.

**If No, Worker has the right to change health care provider after 60 days.**  
En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 días.

**Signed:** \_\_\_\_\_

Firma: (employee/empleado)

Date/Fecha: \_\_\_\_\_

**Signed/Notice Received:** \_\_\_\_\_

Firma/Notificación recibida: (employer or representative/empleador o representante)

Date/Fecha: \_\_\_\_\_

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Form NOA-1

Employer/employee: Each keep one copy.  
Empleador/empleado: Retener una copia.

----SEE BACK OF THIS FORM----  
----VER AL REVERSO DE ESTA FORMA--

# Workers' Compensation

## Workers' Compensation Forms & Documents

Forms

- Notice of Accident or Occupational Disease
- Alternative Notice of Accident (NOA-2 Employee's Choice)
- Employers' First Report of Injury or Illness
- Supervisor's Accident Investigation Report
- Report of Work Ability





# Workers' Compensation NMPSIA NOA

RESET FORM

## NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11  
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29, Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, \_\_\_\_\_ was involved in an on-the-job accident or was disabled by an occupational disease  
Yo, (name of employee/nombre del empleado) me lastimé en un accidente en el trabajo o fui incapacitado por enfermedad de oficio

at approximately \_\_\_\_\_, on \_\_\_\_\_, 20\_\_\_\_ Date of Hire \_\_\_\_\_ Employee's Date of Birth \_\_\_\_\_  
proximadamente (time/a la(s) hora(s)) el (date/fecha) (del 20\_\_\_\_) (fecha de empleo) (fecha de nacimiento)

Employee's social security number: \_\_\_\_\_ Employee's Home Address: \_\_\_\_\_  
Número de seguro social del empleado: Dirección del empleado

Employee's Telephone Number(s): Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Other: \_\_\_\_\_  
Número de teléfono(s): (Casa) (Celular) (Otro)

Where did the accident occur? \_\_\_\_\_  
¿Dónde ocurrió el accidente?

What happened? \_\_\_\_\_  
¿Qué ocurrió?

**Worker will choose health care provider. Employer has right to change health care provider after 60 days.**  
Trabajador elegirá el proveedor de atención médica. El empleador tiene el derecho de cambiar el proveedor de atención médica después de 60 días

Signed: \_\_\_\_\_  
Firma: (employee/empleado)

Signed/Notice Received: \_\_\_\_\_  
Firma/Notificación recibida: (employer or representative/empleador o representante)

Date/Fecha: \_\_\_\_\_

Date/Fecha: \_\_\_\_\_

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**PREVIOUS NOA FORMS ARE STILL VALID FOR USE**

# Workers' Compensation

## Workers' Compensation Forms & Documents

Forms

- Notice of Accident or Occupational Disease
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# Workers' Compensation

## Workers' Compensation Forms & Documents

### Forms

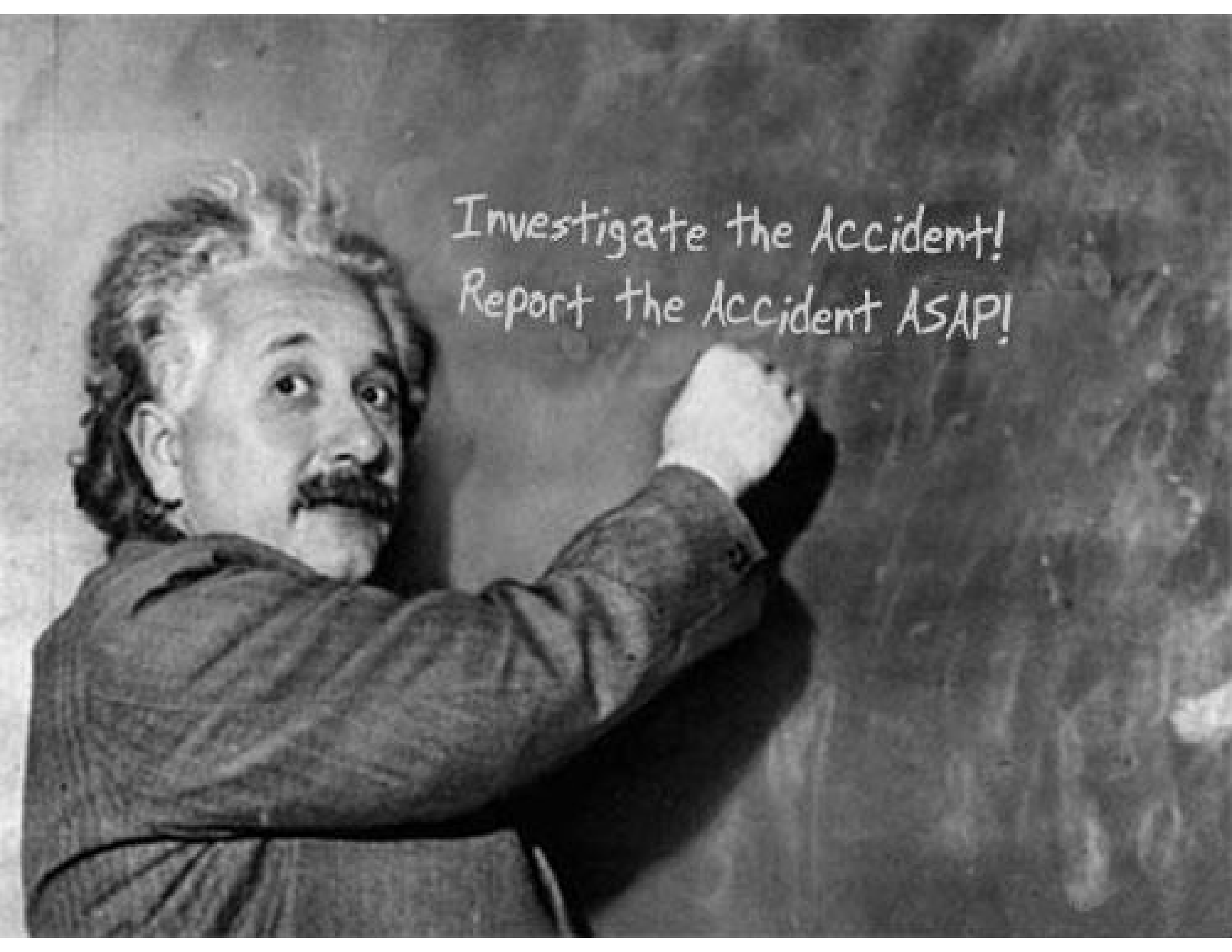
- Notice of Accident or Occupational Disease
- Alternative Notice of Accident (NOA-2 Employee's Choice)
- Employers' First Report of Injury or Illness
- Supervisor's Accident Investigation Report
- Report of Work Ability



# Workers' Compensation Investigation

## SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

GENERAL INFORMATION	DEPARTMENT		SHIFT	
	EMPLOYEE NAME		JOB TITLE	
	EMPLOYEE NUMBER		SEX (M/F)	
	TYPE OF ACCIDENT/ILLNESS			
	TYPE OF INJURY			
	PART OF BODY INJURED	TREATMENT <input type="checkbox"/> FIRST AID <input type="checkbox"/> MEDICAL	DID EMPLOYEE RETURN TO WORK THE SAME DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WHERE DID THE ACCIDENT HAPPEN? USE ADDITIONAL SHEETS IF NECESSARY			
DESCRIPTION	SPECIFIC MACHINE, TOOL, SUBSTANCE OR OBJECT CONNECTED WITH THE ACCIDENT			
	UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIME OF ACCIDENT (Be Specific)			
	PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)			
	PERSONAL PROTECTIVE EQUIPMENT REQUIRED			
	WAS INJURED EMPLOYEE USING REQUIRED EQUIPMENT?			
RECOMMENDATIONS	ACTION PLAN TO PREVENT RECURRENCE (Modification of Machine, Mechanical Guarding, Environment, Training)			
	SUPERVISOR'S SIGNATURE _____		DATE _____	
FOLLOW-UP	ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)			

A black and white photograph of Albert Einstein, with his characteristic wild hair and mustache, wearing a dark jacket. He is standing in front of a chalkboard, looking towards the camera with a slight smile. His right hand is raised, holding a piece of chalk, as if he has just finished writing or is about to write. The chalkboard is filled with faint, illegible markings, but two lines of text are clearly visible in the upper right quadrant.

Investigate the Accident!  
Report the Accident ASAP!

## Workers' Compensation

### Why should the School investigate?

- Assist in the claims process at time of the incident.
- To be the “eyes and ears” in the field
- To gather facts on-site before they change.
- To preserve evidence that may be lost over time
- To identify ways to prevent accidents from recurring

# Workers Compensation

## NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Sections 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978, NMAC 11.4.4.11  
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29, Sección 52-3-19 y Sección 52-1-49, NMSA 1978, NMAC 11.4.4.11

I, \_\_\_\_\_, was involved in an on-the-job accident or was disabled by an occupational disease  
Yo, \_\_\_\_\_, me lesioné en un accidente en el trabajo o fui incapacitado por enfermedad de oficio  
at approximately (dónde y a qué hora) on \_\_\_\_\_, 20\_\_\_\_, Date of Hire \_\_\_\_\_ Employee's Date of Birth \_\_\_\_\_  
provisoriamente (dónde y a qué hora) el \_\_\_\_\_, 20\_\_\_\_, (fecha de empleo) (fecha de nacimiento)

Employee's social security number: \_\_\_\_\_ Employee's Home Address: \_\_\_\_\_  
Número de seguro social del empleado: \_\_\_\_\_ Dirección del empleado \_\_\_\_\_

Employee's Telephone Number(s): Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Other: \_\_\_\_\_  
Número de teléfono(s): (Casa) (Celular) (Otro)

Where did the accident occur?  
¿Dónde ocurrió el accidente?  
What happened?  
¿Qué ocurrió?

**Worker will choose health care provider. Employer has right to change health care provider after 60 days.**  
**Trabajador elegirá proveedor de atención médica. El empleador tiene el derecho de cambiar el proveedor de atención médica después de 60 días**

Signed \_\_\_\_\_ Signed/Notice Received: \_\_\_\_\_  
Firma: (employee/empleada) Firma/Notificación recibida: (employer or representative/empleador o representante)  
Date/Fecha: \_\_\_\_\_ Date/Fecha: \_\_\_\_\_

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

### PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Worker (Trabajador)  
For emergency medical care, go to any emergency medical facility. (Para emergencias médicas vaya a cualquier clínica / hospital)

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

(Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor (ombudsman) en cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de días festivos.)

Statewide Helpline -- Línea de Asistencia  
**1-866-WORKOMP / 1-866-967-5667**  
toll free -- llamada sin costo de larga distancia  
New Mexico Workers' Compensation Administration  
PO Box 27198, Albuquerque, NM 87125

Albuquerque: (505) 841-8200 - 1 (800) 255-7985 Las Vegas: (505) 454-9251 - 1 (800) 261-7889 Santa Fe: (505) 476-7381  
Farmington: (505) 599-9745 - 1 (800) 556-7310 Lovington: (575) 398-3437 - 1 (800) 934-2450 TDD for the deaf: (505) 841-6043  
Las Cruces: (575) 524-6245 - 1 (800) 870-6826 Roswell: (575) 623-3997 - 1 (800) 311-9587 [www.newmexicoworkerscomp.state.nm.us](http://www.newmexicoworkerscomp.state.nm.us)

**Employer/employee: Each keep one copy.**  
**Empleador/empleado: Retener una copia.**

Form NOA-2- NMPPIA 2015

22

Email these forms to CCMSI  
dedicated WC email:  
[nmpsiawc@ccmsi.com](mailto:nmpsiawc@ccmsi.com)

### Individual Supervisor's Accident Investigation Report Form

GENERAL INFORMATION	DEPARTMENT	SHIFT
	EMPLOYEE NAME	JOB TITLE
	EMPLOYEE NUMBER	SEX (M/F)
DESCRIPTION	TYPE OF ACCIDENT/ILLNESS	
	TYPE OF INJURY	
	PART OF BODY INJURED	TREATMENT
	DID EMPLOYEE RETURN TO WORK THE SAME DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WHERE DID THE ACCIDENT HAPPEN? USE ADDITIONAL SHEETS IF NECESSARY	
CAUSES	SPECIFIC MACHINE, TOOL, SUBSTANCE OR OBJECT CONNECTED WITH THE ACCIDENT	
	UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIME OF ACCIDENT (Be Specific)	
	PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)	
	PERSONAL PROTECTIVE EQUIPMENT REQUIRED	
	WAS INJURED EMPLOYEE USING REQUIRED EQUIPMENT?	
RECOMMENDATIONS	ACTION PLAN TO PREVENT RECURRENCE (Modification of Machine, Mechanical Guarding, Environment, Training)	
	SUPERVISOR'S SIGNATURE	DATE
FOLLOW-UP	ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)	

27

## NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE • PO BOX 27198  
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT (IN BLACK INK) OR TYPE

GENERAL INFORMATION	EMPLOYER (NAME & ADDRESS (incl. ZIP))	CARRIER / ADMINISTRATOR CLAIM #	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER		
	INSURED REPORT NUMBER	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) LOCATION #		
	INDUSTRY CODE	INDUSTRY CODE		
CLAIM INFORMATION	CARRIER (NAME, ADDRESS & PHONE NO.)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)	
	NMPSIA 410 Old Texas Hwy. Santa Fe, NM 87501	TO	CCMSI (Cannon Cochran Management Services Inc.) P.O. Box 31870 Albuquerque, NM 87180 505-257-9700 505-257-0679	
	CHECK IF APPLICABLE <input type="checkbox"/> SELF INSURANCE	POLICY / SELF-INSURED NUMBER	CLAIMS REPORTER'S ID NUMBER	
	EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S SOCIAL SECURITY NUMBER	
EMPLOYEE INFORMATION	NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED
	ADDRESS (incl. ZIP)	SEX	MARITAL STATUS	OCCUPATION/JOB TITLE OR (JOB) CODE
	PHONE NUMBER	<input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> FEMALE <input type="checkbox"/> UNEMPLOYED	<input type="checkbox"/> SINGLE/UNEMPLOYED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED	EMPLOYMENT STATUS
		# OF DEPENDENTS	<input type="checkbox"/> UNKNOWN	HCID CLASS CODE
INJURY INFORMATION	RATE	PER <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER	# DAYS WORKED/EXPOSED	FULL PAY FOR DAY OF INJURY/ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO
	TIME EMPLOYEE BEGAN WORK	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
	CONTACT NAME (PHONE NUMBER)	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF INJURY / ILLNESS CODE		PART OF BODY AFFECTED CODE
DETAILED INFORMATION	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED	
	SPECIAL ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED	
	HOW INJURY OR ILLNESS (AIRBORNE, HEAT, IN CONDITION OCCURRED) DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.			
	DATE RETURNED TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	CAUSE OF INJURY CODE
TREATMENT	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	
	WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PHYSICAL TREATMENT	
	ATTENDING NURSE (NAME & PHONE #)		<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MAJOR CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL COST THE ANTICIPATED	
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		

NM WCA FORM E1.2

EQUIVALENT TO OSHA'S FORM 301

FORM (A-1) (7/02) © IAABC 2002

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

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# Workers' Compensation FROI

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**  
**EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS**

2410 CENTRE AVE. SE • PO BOX 27198  
 ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE

GENERAL	EMPLOYER (NAME & ADDRESS (NEC. ST.))	CURRENT ADMINISTRATION CLASS #	2014 LOC CLASS #	REPORT PURPOSE CODE
	CORPORATION	ADDRESS/LOCALITY NUMBER	EMPLOYEE ID NUMBER	
CARRIER	CARRIER (NAME, ADDRESS & PHONE NO.)	POLICY PERIOD TO	CLASS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)	
	CLASS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)	TO	CCMSI (Cargous Cochran Management Services Inc.)	
	CLASS #	CLASS #	P.O. Box 30870	
	CLASS #	CLASS #	Albuquerque, NM 87190	
EMPLOYEE	EMPLOYEE (NAME & ADDRESS (NEC. ST.))	EMPLOYEE SOCIAL SECURITY NUMBER	DATE BIRTH	DATE OF 2014
	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE SOCIAL SECURITY NUMBER	DATE BIRTH	DATE OF 2014
INJURY	DATE (CLASS, PERIOD, MONTH)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
	DATE (CLASS, PERIOD, MONTH)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
DETAILS	CONTACT NAME (PHONE NUMBER)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
	CONTACT NAME (PHONE NUMBER)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
SPECIFIC	DATE (CLASS, PERIOD, MONTH)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
	DATE (CLASS, PERIOD, MONTH)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
TREATMENT	PHYSICIAN (NAME & ADDRESS)	HOSPITAL (NAME & ADDRESS)	DATE BIRTH	DATE OF 2014
	PHYSICIAN (NAME & ADDRESS)	HOSPITAL (NAME & ADDRESS)	DATE BIRTH	DATE OF 2014
OTHER	DATE (CLASS, PERIOD, MONTH)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH
	DATE (CLASS, PERIOD, MONTH)	TYPE OF INJURY	TIME OF OCCURRENCE	DATE BIRTH

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

# Workers' Compensation FROI GENERAL Section

PLEASE PRINT IN BLACK INK OR TYPE.

<b>G E N E R A L</b>	<b>EMPLOYER ( NAME &amp; ADDRESS INCL ZIP )</b>		<b>CARRIER / ADMINISTRATOR CLAIM #</b>	<b>OSHA LOG NUMBER</b>	<b>REPORT PURPOSE CODE</b>
				<b>JURISDICTION</b>	<b>JURISDICTION CLAIM NUMBER</b>
	<b>INSURED REPORT NUMBER</b>				
	<b>EMPLOYER'S LOCATION ADDRESS ( IF DIFFERENT )</b>				<b>LOCATION #</b>
	<b>PHONE NUMBER</b>	<b>EMPLOYER FEIN</b>			

# Workers' Compensation FROI CARRIER Section

<b>C A R R I E R</b>	<b>C L A I M S A D M I N</b>	CARRIER ( NAME, ADDRESS & PHONE NO )		POLICY PERIOD	CLAIMS ADMINISTRATOR ( NAME, ADDRESS & PHONE NO )		
		NMPSIA 410 Old Taos Hwy. Santa Fe, NM 87501		TO	CCMSI (Cannon Cochran Management Services Inc.) P.O. Box 30870 Albuquerque, NM 87190 505-837-8700 / 800-635-0679		
		CARRIER FEIN <b>850365637</b>		CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE		ADMINISTRATOR FEIN 841094892	
		AGENT NAME & CODE NUMBER		POLICY / SELF-INSURED NUMBER			

# Workers' Compensation FROI EMPLOYEE Section

<b>E M P L O Y E E</b>	<b>NAME (LAST, FIRST, MIDDLE)</b>	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY NUMBER</b>	<b>DATE HIRED</b>	<b>STATE OF HIRE</b>	
	<b>ADDRESS (INCL ZIP)</b>	<b>GENDER</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		<b>MARITAL STATUS</b> <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		
	<b>PHONE NUMBER</b>	<b># OF DEPENDENTS</b>		<b>OCCUPATION/JOB TITLE OR (SOC) CODE</b>		
				<b>EMPLOYMENT STATUS</b>		
				<b>NCCI CLASS CODE</b>		

# Workers' Compensation FROI WAGE Section

<b>W A G E</b>	<b>RATE</b>	<b>PER:</b>	<input type="checkbox"/> DAY	<input type="checkbox"/> MONTH	<b># DAYS WORKED/WEEK</b>	<b>FULL PAY FOR DAY OF INJURY?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> WEEK	<input type="checkbox"/> OTHER:		<b>DID SALARY CONTINUE?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

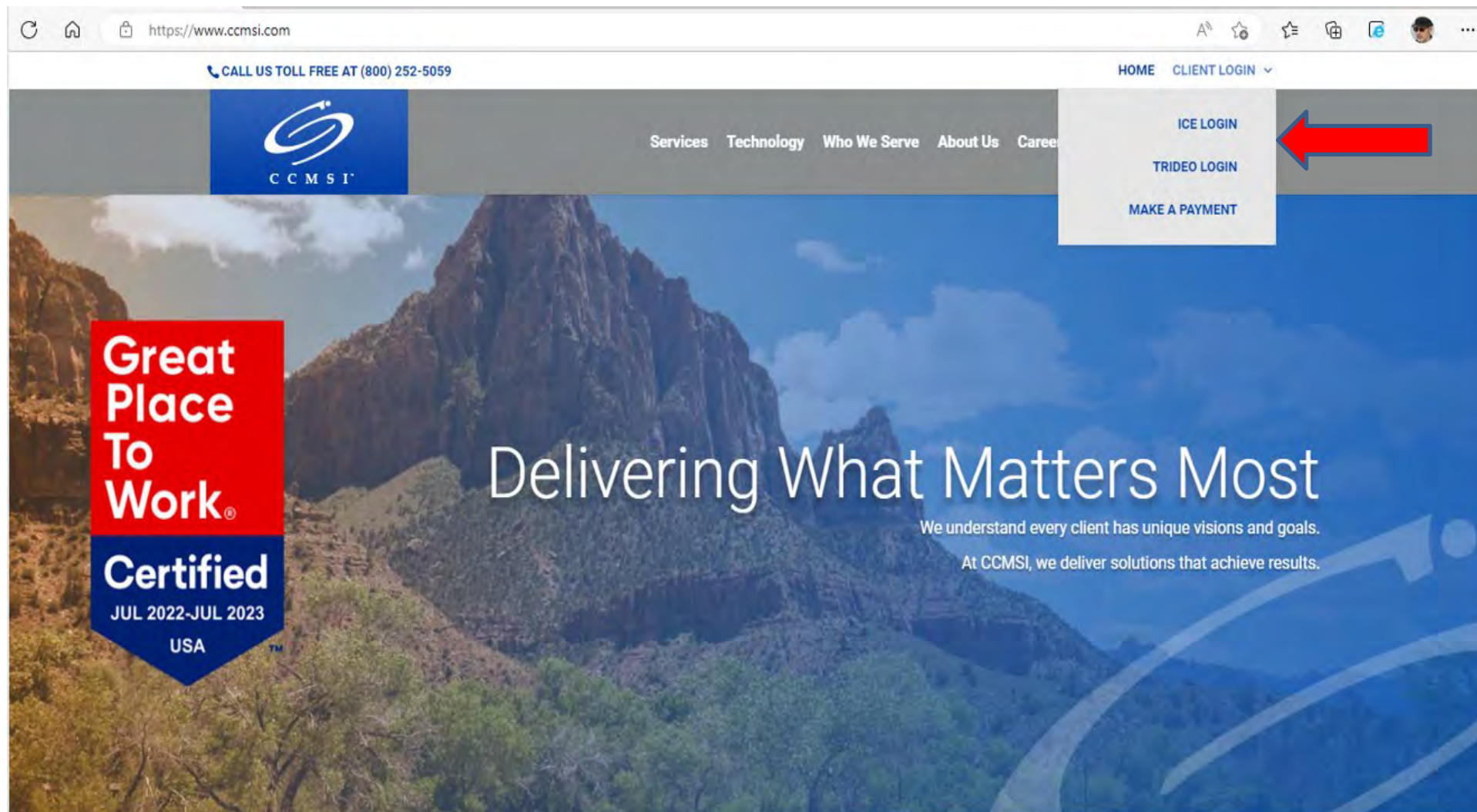
# Workers' Compensation FROI OCCURRENCE Section

O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN	
	CONTACT NAME / PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY / ILLNESS CODE			PART OF BODY AFFECTED CODE		
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
	HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.								CAUSE OF INJURY CODE
	DATE RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
					WERE THEY USED?			<input type="checkbox"/> YES <input type="checkbox"/> NO	

# Workers' Compensation FROI TREATMENT & OTHER Sections

<b>T R E A T M E N T</b>	PHYSICIAN / HEALTH CARE PROVIDER ( NAME & ADDRESS )	HOSPITAL ( NAME & ADDRESS )	<b>INITIAL TREATMENT</b> <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
<b>O T H E R</b>	WITNESSES ( NAME & PHONE # )		
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE

# Workers' Compensation Electronic Reporting



CALL US TOLL FREE AT (800) 252-5059

HOME CLIENT LOGIN ▾

- ICE LOGIN
- TRIDEO LOGIN
- MAKE A PAYMENT

Services Technology Who We Serve About Us Career

**Great Place To Work<sup>®</sup>**

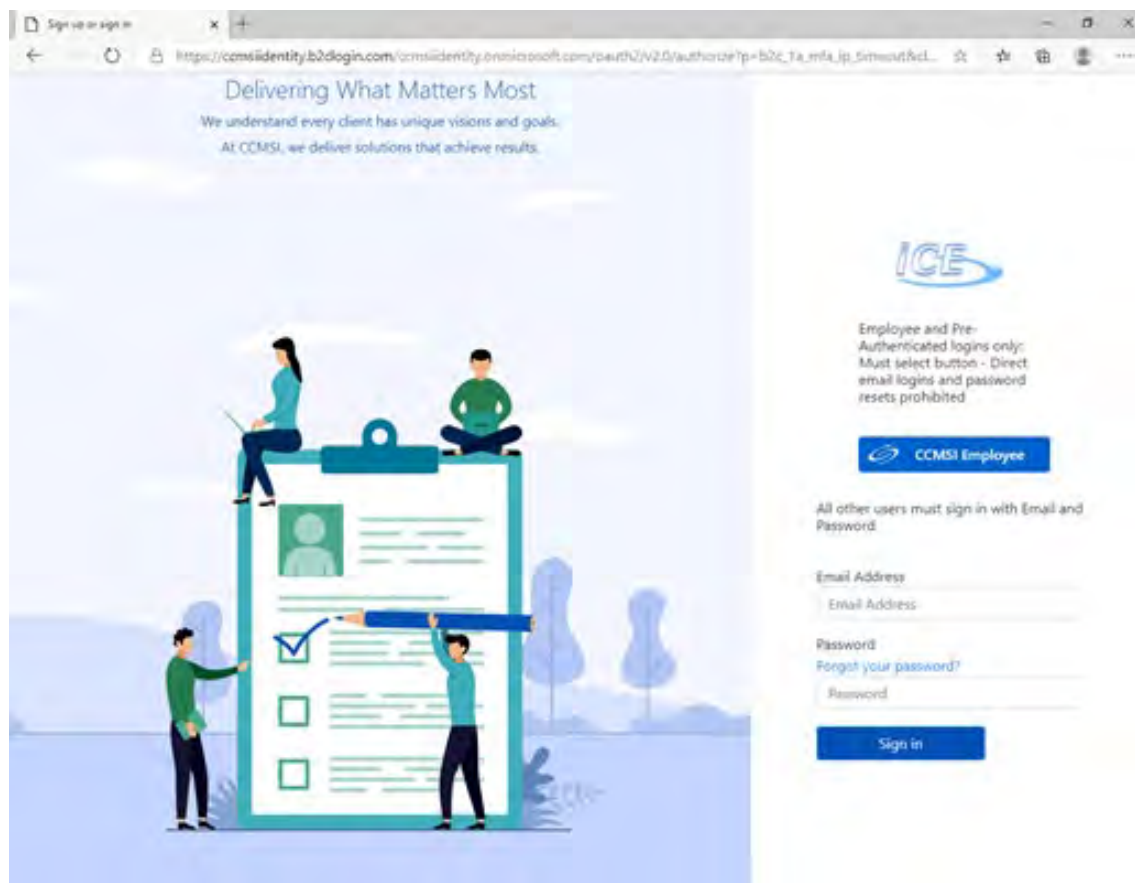
**Certified**  
JUL 2022-JUL 2023  
USA

## Delivering What Matters Most

We understand every client has unique visions and goals.  
At CCMSI, we deliver solutions that achieve results.



# Workers' Compensation Internet Claims Edge (ICE)



The screenshot shows a web browser window with the URL [https://ccmsidentity.b2dlogin.com/ccmsidentity.onmicrosoft.com/9a470212-0/authorize?sp=b2c\\_1a\\_mfa\\_ip\\_siteword&cL...](https://ccmsidentity.b2dlogin.com/ccmsidentity.onmicrosoft.com/9a470212-0/authorize?sp=b2c_1a_mfa_ip_siteword&cL...). The page features a header with the text "Delivering What Matters Most" and "We understand every client has unique visions and goals. At CCMSI, we deliver solutions that achieve results." Below this is an illustration of three people interacting with a large digital checklist. On the right side, the "ICE" logo is displayed, followed by the text: "Employee and Pre-Authenticated logins only: Must select button - Direct email logins and password resets prohibited". There are two main login options: a blue button labeled "CCMSI Employee" and a section for "All other users must sign in with Email and Password". This section includes input fields for "Email Address" and "Password", with a "Forgot your password?" link. A "Sign in" button is located at the bottom of the form.

## Workers' Compensation

welcome  
to the edge.



*ice*

**New Look and Functionality!**

one cool name. one hot solution.

Help Desk 888-578-5555 x8062

## Workers' Compensation



internet claims edge



### Welcome!

CCMSI's Internet Claims Edge, or "iCE", is the comprehensive claims analysis and reporting tool that empowers a user with ease and flexibility to produce a variety of reports, charts and graphs.

iCE will assist in tracking claims or analyzing trends. iCE will significantly enhance your claims management process.

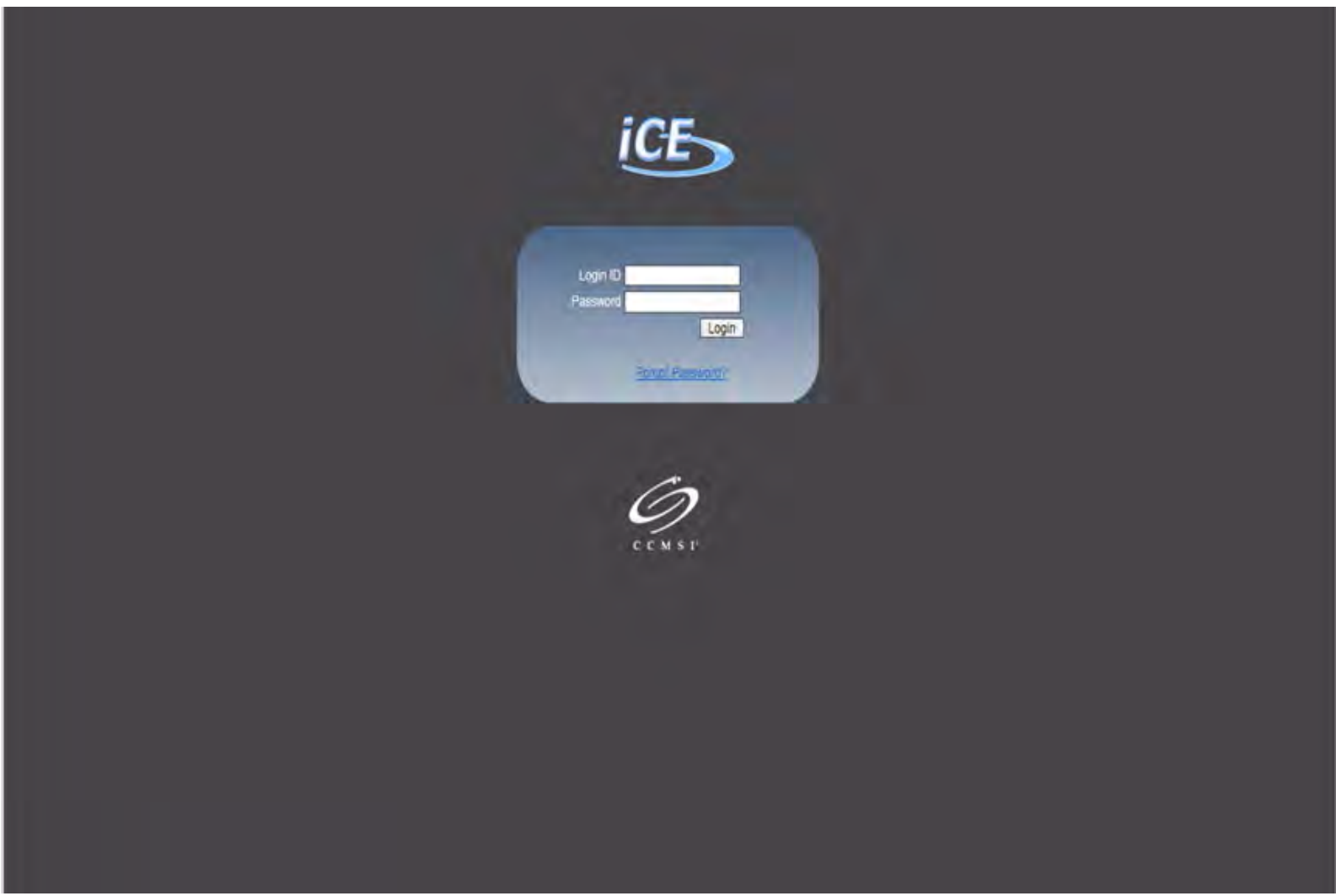


<https://ice.ccmsi.com>

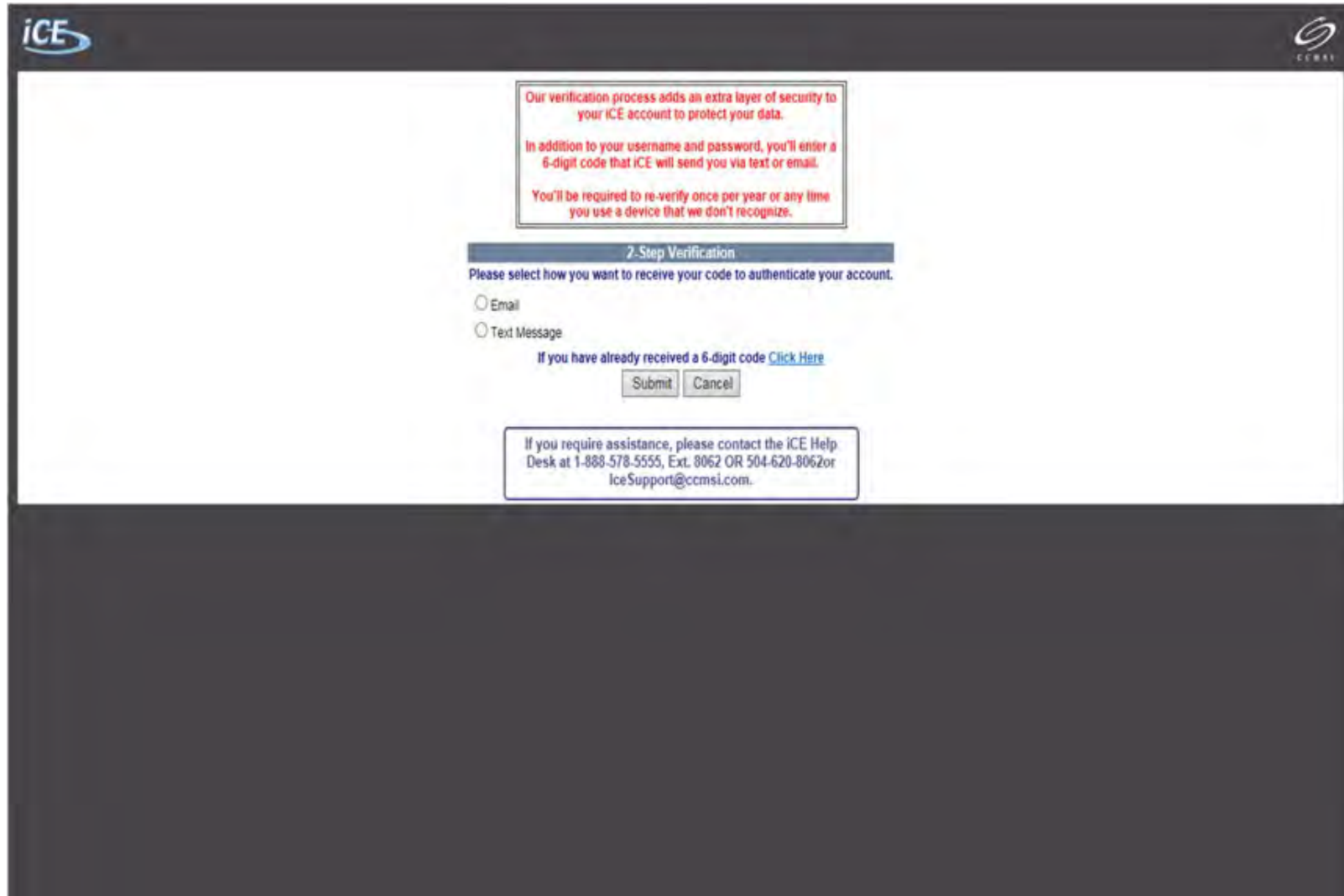
## Workers' Compensation



# Workers' Compensation



# Workers' Compensation



The screenshot shows a web interface for ICE (Insurance Coverage Exchange) with a 2-Step Verification process. The interface includes the ICE logo in the top left and the CCMSI logo in the top right. A central text box explains the verification process, followed by a section titled "2-Step Verification" with radio button options for "Email" and "Text Message". Below these options are "Submit" and "Cancel" buttons. A final text box at the bottom provides contact information for ICE Help Desk.

**ICE**

**CCMSI**

Our verification process adds an extra layer of security to your ICE account to protect your data.

In addition to your username and password, you'll enter a 6-digit code that ICE will send you via text or email.

You'll be required to re-verify once per year or any time you use a device that we don't recognize.

**2-Step Verification**

Please select how you want to receive your code to authenticate your account.

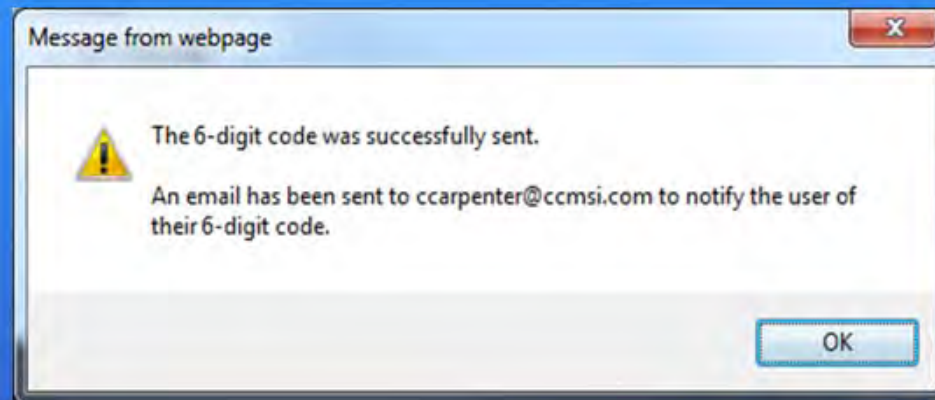
Email

Text Message

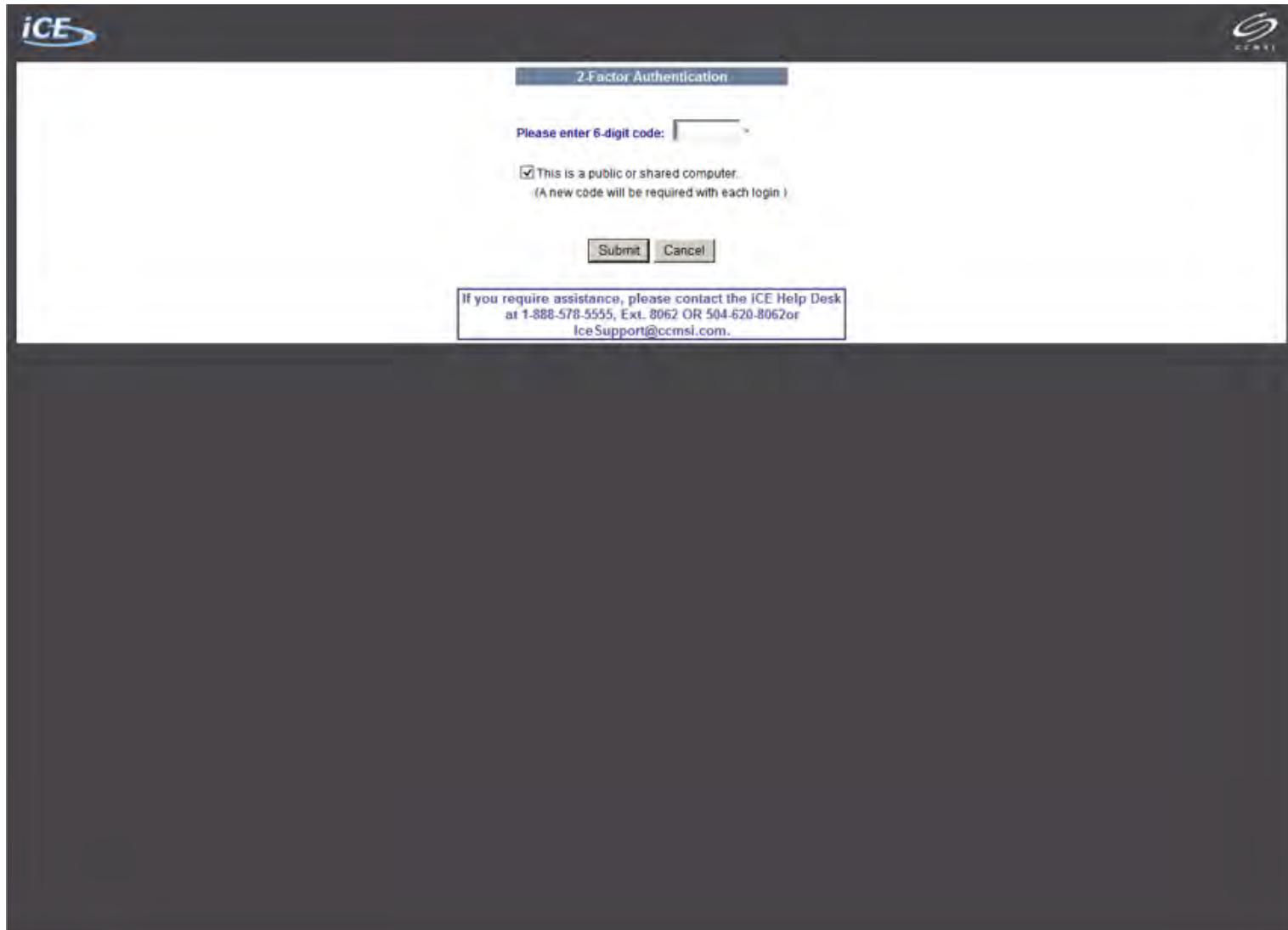
If you have already received a 6-digit code [Click Here](#)

If you require assistance, please contact the ICE Help Desk at 1-888-578-5555, Ext. 8062 OR 504-620-8062 or [IceSupport@ccmsi.com](mailto:IceSupport@ccmsi.com).

# Workers' Compensation



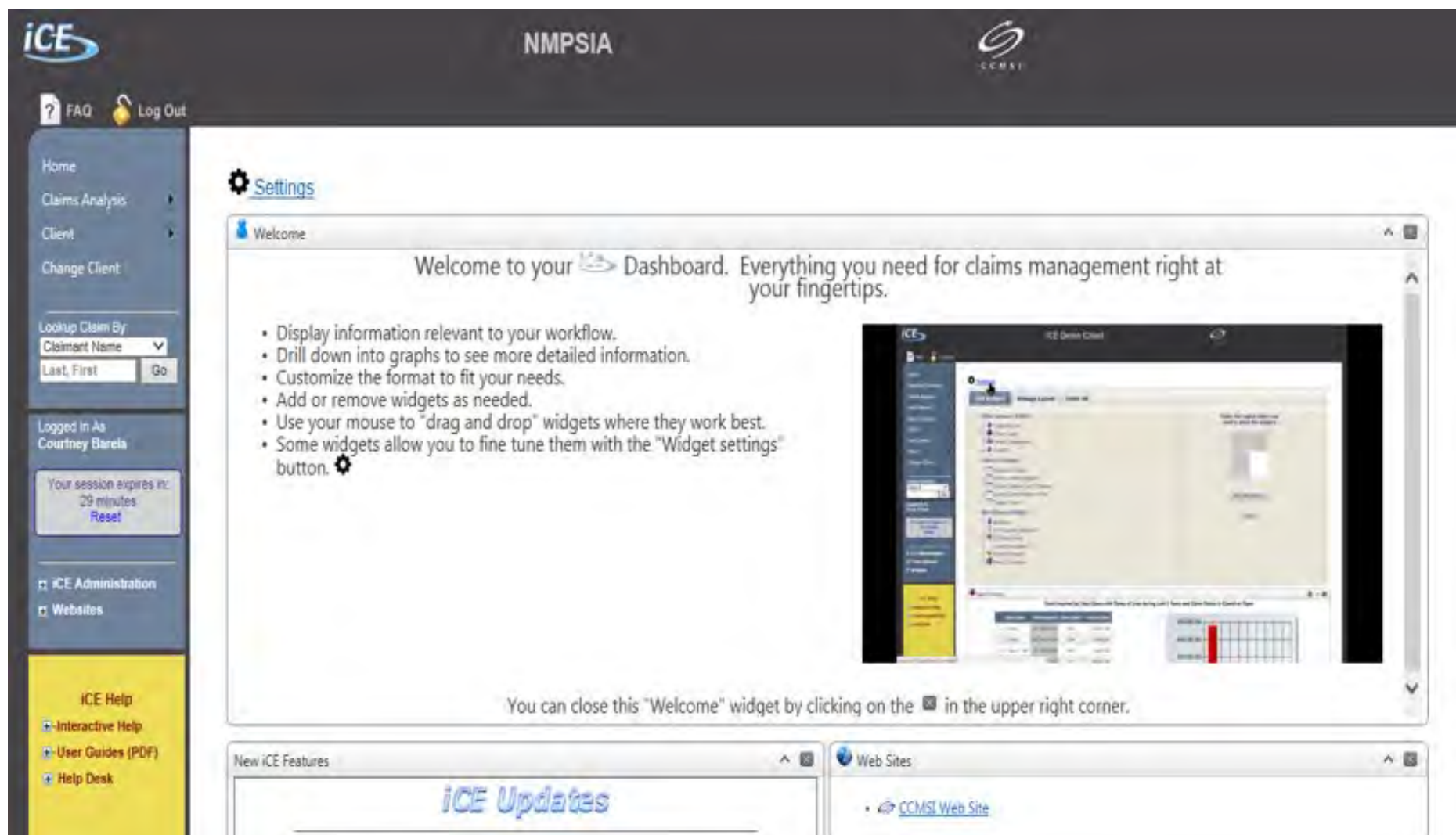
# Workers' Compensation



The screenshot shows a web interface for 2-Factor Authentication. At the top left is the 'ICE' logo and at the top right is the 'CCMSI' logo. The main content area has a title bar '2-Factor Authentication'. Below it, the text 'Please enter 6-digit code:' is followed by a text input field. A checkbox is checked, with the text 'This is a public or shared computer. (A new code will be required with each login)'. Below the checkbox are two buttons: 'Submit' and 'Cancel'. At the bottom, a box contains the text: 'If you require assistance, please contact the ICE Help Desk at 1-888-578-5555, Ext. 8062 OR 504-620-8062 or IceSupport@ccmsi.com.'



# Workers' Compensation

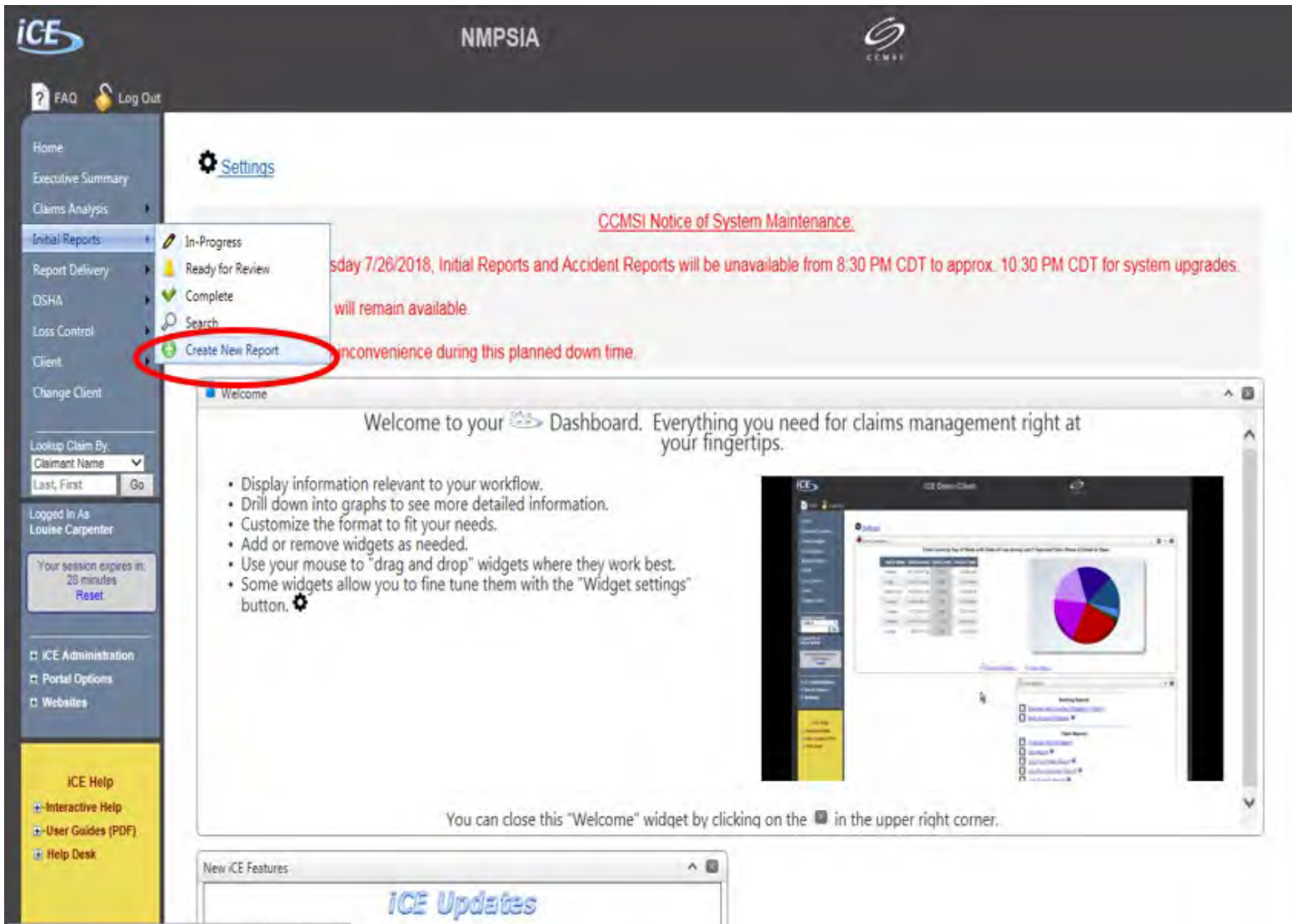


The screenshot shows the iCE NMPSIA dashboard interface. At the top, there are logos for iCE, NMPSIA, and CCMSI. A navigation menu on the left includes Home, Claims Analysis, Client, Change Client, and a search bar for claim lookup. The main content area is titled 'Settings' and features a 'Welcome' widget. This widget contains a list of instructions for using the dashboard:

- Display information relevant to your workflow.
- Drill down into graphs to see more detailed information.
- Customize the format to fit your needs.
- Add or remove widgets as needed.
- Use your mouse to "drag and drop" widgets where they work best.
- Some widgets allow you to fine tune them with the "Widget settings" button.

To the right of the text is a smaller screenshot of the dashboard showing a 'Widget Control' panel. Below the instructions, a note states: "You can close this 'Welcome' widget by clicking on the [close icon] in the upper right corner." At the bottom of the dashboard, there are sections for 'New iCE Features' (with a link to 'iCE Updates') and 'Web Sites' (with a link to 'CCMSI Web Site').

# Workers' Compensation



The screenshot shows the iCE NMPSIA web application interface. The top navigation bar includes the iCE logo, NMPSIA text, and the CCMSI logo. A left sidebar contains a menu with options like Home, Executive Summary, Claims Analysis, Initial Reports, Report Delivery, OSHA, Loss Control, Client, and Change Client. The 'Initial Reports' menu is expanded, showing sub-options: In-Progress, Ready for Review, Complete, Search, and Create New Report. The 'Create New Report' option is circled in red. A red text overlay reads: "CCMSI Notice of System Maintenance. On Thursday 7/26/2018, Initial Reports and Accident Reports will be unavailable from 8:30 PM CDT to approx. 10:30 PM CDT for system upgrades. All other reports will remain available. We apologize for the inconvenience during this planned down time." Below this, a 'Welcome' widget displays a dashboard overview with a list of features:
 

- Display information relevant to your workflow.
- Drill down into graphs to see more detailed information.
- Customize the format to fit your needs.
- Add or remove widgets as needed.
- Use your mouse to "drag and drop" widgets where they work best.
- Some widgets allow you to fine tune them with the "Widget settings" button.

 An inset image shows a detailed view of the dashboard with a pie chart and various data widgets. At the bottom, there is a 'New iCE Features' section and an 'ICE Updates' section.

# Workers' Compensation

ICE NMPSIA



FAQ Log Out In-Progress Ready for Review Complete Search **Create New Report**

### In-Progress Initial Report Forms

(458 In-Progress Initial Reports)

Created	Last Updated	Name	Date of Loss	Coverage	Report Type	State of Jurisdiction	Accident Description	Location	Location2	
6/27/2018	7/26/2018		6/27/2018	WC	REPORT ONLY	NM	Fell off 3 foot ladder stepping down Rm. 314 at Y			X
7/19/2018	7/19/2018		7/19/2018	WC	CLAIM	NM	Tripped and hit lower right leg			X
6/18/2018	6/18/2018		6/13/2018	WC	REPORT ONLY	NM	Tripped Over Mop Bucket			X
6/13/2018	6/13/2018		11/3/2017	WC	CLAIM	NM	EE bit by student on middle part of the arm			X
6/4/2018	6/4/2018		6/4/2018	WC	REPORT ONLY	NM	metal from desk cut finger			X
5/23/2018	5/24/2018		5/23/2018	WC	REPORT ONLY	NM	Shelf fell on foot			X
5/21/2018	5/21/2018		5/18/2018	WC	CLAIM	NM	Tangled in computer cords			X
5/17/2018	5/17/2018		5/15/2018	PFC	CLAIM	NM	Pulled a muscle lifting files			X
5/15/2018	5/15/2018		5/15/2018	PFC	CLAIM	NM	Cut finger on can lid.			X
10/10/2017	5/10/2018		10/10/2017	WC	CLAIM	NM	strained back bending to break up fight			X
5/10/2018	5/10/2018		3/6/2018	WC	CLAIM	NM	tripped and fell landing on my shoulder			X
5/10/2018	5/10/2018		3/6/2018	WC	CLAIM	NM	tripped and fell landing on my shoulder			X
5/9/2018	5/9/2018		5/8/2018	WC	REPORT ONLY	NM	Walking Up Stairs			X
5/4/2018	5/4/2018		4/24/2018	WC	REPORT ONLY	NM	Contact with contaminated hypodermic needle			X
4/9/2018	5/3/2018		4/9/2018	WC	REPORT ONLY	NM	fell off broken chair			X
5/2/2018	5/2/2018		4/17/2018	WC	CLAIM	NM				X
5/2/2018	5/2/2018		5/1/2018	WC	CLAIM	NM				X
4/27/2018	4/27/2018		4/23/2018	WC	REPORT ONLY	NM	CHAIR SLIPPED OUT FROM UNDER HITTING BACK AND KNEE			X
3/15/2018	3/15/2018		3/14/2018	WC	CLAIM	NM	EMPLOYEE FELL AND HIT HEAD AND BACK			X
3/14/2018	3/14/2018		3/14/2018	WC	CLAIM	NM				X
3/12/2018	3/13/2018		3/12/2018	WC	REPORT ONLY	NM	Jarred neck			X

# Workers' Compensation

FAQ
Log Out
In-Progress
Ready for Review
Complete
Search
Create New Report

- Home
- Executive Summary
- Claims Analysis
- Initial Reports
- Report Delivery
- OSHA
- Loss Control
- Client
- Change Client

Lookup Claim By:

Claimant Name

Logged In As  
Louise Carpenter

Your session expires in:  
29 minutes

- ICE Administration
- Portal Options
- Websites

ICE Help

- + Interactive Help
- + User Guides (PDF)
- + Help Desk

### Initial Report Form

**General Information**

Claim Number:	(Unassigned)	Alternate Claim Number:	<input type="text"/>
Occurrence Number:	(Unassigned) <input type="button" value="🔍"/>		
Location:	<input type="text"/>		
LocationZ:	<input type="text"/>		
Date of Loss:	<input type="text"/>	Time of Loss:	<input type="text" value="00:00 - 23:59"/>
Date Reported:	<input type="text" value="7/26/2018"/>		
Covg Code:	<input type="text"/>	Report Type:	<input type="text"/>

**Claimant's Personal Information**

Claimant ID:      Social Security Num     Perm. Resident ID     Empl. Visa ID     Federal ID

Employee ID:

Last Name:  \*    First Name:  \*    Middle Name:

Physical Address

Country:  United States     Canada     Other \*

Street Address:  \*

Street Address 2:

City:  \*    State:  \*    Zipcode:  \*

County:

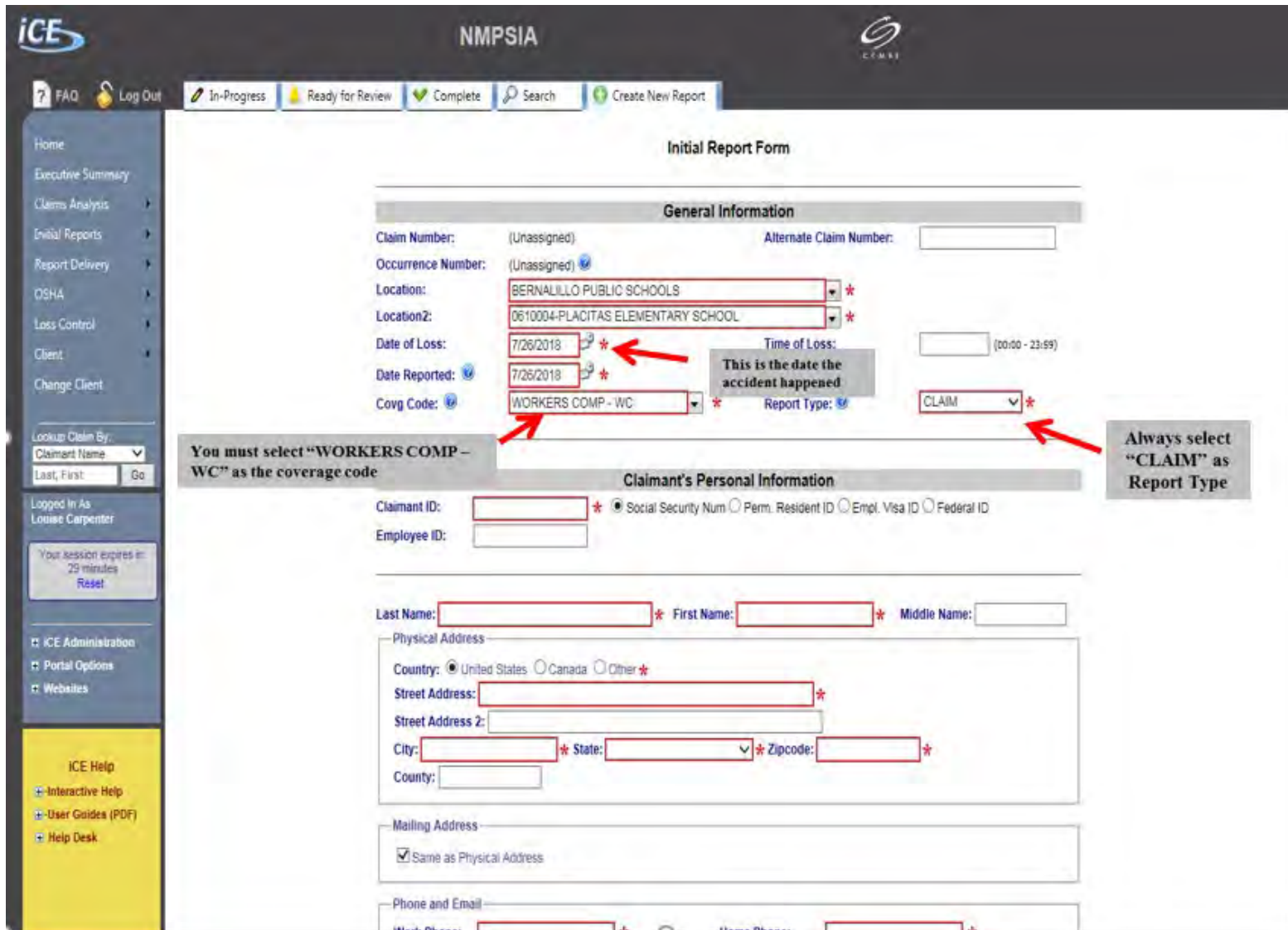
Mailing Address

Same as Physical Address

Phone and Email

Work Phone:  \*    Home Phone:  \*

# Workers' Compensation



**iCE NMPSIA**

Initial Report Form

**General Information**

Claim Number: (Unassigned) Alternate Claim Number:

Occurrence Number: (Unassigned)

Location:  \*

Location2:  \*

Date of Loss:  \*  \* Time of Loss:  (00:00 - 23:59)

Date Reported:  \*

Covg Code:  \* Report Type:  \*

**You must select "WORKERS COMP - WC" as the coverage code**

**This is the date the accident happened**

**Always select "CLAIM" as Report Type**

**Claimant's Personal Information**

Claimant ID:  \*  Social Security Num  Perm. Resident ID  Empl. Visa ID  Federal ID

Employee ID:

Last Name:  \* First Name:  \* Middle Name:

**Physical Address**

Country:  United States  Canada  Other \*

Street Address:  \*

Street Address 2:

City:  \* State:  \* Zipcode:  \*

County:

**Mailing Address**

Same as Physical Address

**Phone and Email**

Work Phone:  \* Home Phone:  \*



# Workers' Compensation

[User Guides \(PDF\)](#)  
[Help Desk](#)

Mailing Address

Same as Physical Address

Phone and Email

Work Phone:  \*      Home Phone:  \*

Cell Phone:

Work Email:       Personal Email:

Date of Birth:  \*

Marital Status:       Gender:  Male  Female  Unknown

---

Incident Information

Loss Cause:  \*

Loss Type:

Body Part:

Accident Stat:

Accident Loc:

Drivers Licen:

Accident Des:

Claim Summ:

Initial Med:  None

Witnesses:

Group/Analysis Codes

Group Codes:  \*      Cause:  \*

# Workers' Compensation

[User Guides \(PDF\)](#)  
[Help Desk](#)

---

**Mailing Address**

Same as Physical Address

---

**Phone and Email**

Work Phone:  \*      Home Phone:  \*

Work Email:       Cell Phone:

Personal Email:

---

Date of Birth:  \*

Marital Status:       Gender:  Male  Female  Unknown

---

**Incident Information**

Loss Cause:  \*

Loss Type:  \*

Body Part:  \*

Accident Status:  \*

Accident Location:

Drivers License:

Accident Description:

Claim Summary:

Initial Medical:  None

Witness:

---

**Group/Analysis Codes**

Group Codes: OCCUPATION:  \*      Cause:  \*

Special Analysis Codes:  \*



# Workers' Compensation

Claim Summary: (Include any relevant details)

Initial Medical Treatment  
 None Required  Refused  First Aid Only  Physician/Treatment Facility Visit  Emergency Room Visit

Witnesses

**Group/Analysis Codes**

Group Codes:  \* Special Analysis Codes:  \*

OCCUPATION:  \* Cause:  \*

TYPE:

SUBCLASS: 7300 - BUS AIDE  
 7300BD - BUS DRIVER  
 7300M - MECHANIC  
 8000 - ADMINISTRATOR  
 8000C - COACHES  
 8000N - NURSE  
 8000P - PAYROLL/SECRETARY  
 8000SA - SPECIAL EDUCATION  
 8000T - TEACHER  
 8000TA - TA-AIDE  
 9015 - CUSTODIAN  
 9015M - MAINTENANCE  
 9002 - CAFETERIA  
 9101 - OTHER

Special Analysis 4:

Special Analysis 5:

Compensation/Jones Act Only

OR Returned to Fulltime Date:

**Do not use NOT APPLICABLE**

Zipcode Injury Site:  \*

Salary Continued In Lieu of Compensation:  Yes  No \*

Full Wages Paid Day Injured:  Yes  No \*

Employment:  \*

Hire Date:  \*

Rate of Pay: \$  \*  Hourly  Daily  Weekly  BiWeekly  Semi-Monthly  Monthly  Annually \*

Job Code:  Job Title (Carrier):  \*

**Attachments**

# Workers' Compensation

**Claim Summary:** (Include any relevant details)

**Initial Medical Treatment:**

None Required
  Refused
  First Aid Only
  Physician/Treatment Facility Visit
  Emergency Room Visit

**Witnesses:**

**Group/Analysis Codes**

<p><b>Group Codes:</b></p> <p>OCCUPATION: <input type="text" value=""/> *</p> <p>TYPE: <input type="text" value=""/> *</p> <p>SUBCLASS: <input type="text" value="100 - MSD NOT APPLICABLE"/></p>	<p><b>Special Analysis Codes:</b></p> <p>Cause: <input type="text" value=""/> *</p> <p>Special Analysis 4: <input type="text" value=""/></p> <p>Special Analysis 5: <input type="text" value=""/></p>
---	---

**Work**

Select NOT APPLICABLE

Lost Time:  Yes  No \*  
 Date Last Worked:   
 Returned to Work:  Yes  No  
 Returned to Light Duty Date:  OR Returned to Fulltime Date:   
 Employee Died Because of Accident:  Yes  No \*

Zipcode Injury Site:  \*  
 Salary Continued In Lieu of Compensation:  Yes  No \*  
 Employment:  \*  
 Rate of Pay: \$  \*  Hourly  Daily  Weekly  BiWeekly  Semi-Monthly  Monthly  Annually \*  
 Job Code:  Job Title (Carrier):  \*

**Attachments**

# Workers' Compensation

**Claim Summary:** (Include any relevant details)

**Initial Medical Treatment:**  
 None Required  Refused  First Aid Only  Physician/Treatment Facility Visit  Emergency Room Visit

**Witnesses:**

**Group/Analysis Codes**

**Group Codes:**  
 OCCUPATION:  \*  
 TYPE:  \*  
 SUBCLASS:  \*

**Special Analysis Codes:**  
 Cause:  \*  
 Special Analysis 4:   
 Special Analysis 5:

**Compensation/Jones Act Only**

Lost Time:  Yes  No  
 Date Last Worked: N/A  
 Returned to Work: OTHER VEHICLE  
 Returned to Light: VAN

OR Returned to Fulltime Date:

Employee Died Because of Accident:  Yes  No \*

Zipcode Injury Site:  \*

Salary Continued In Lieu of Compensation:  Yes  No \*  
 Full Wages Paid Day Injured:  Yes  No \*

Employment:  \*  
 Hire Date:  \*

Rate of Pay: \$  \*  Hourly  Daily  Weekly  Bi/Weekly  Semi-Monthly  Monthly  Annually \*

Job Code:  \*  
 Job Title (Carrier):  \*

**Attachments**

# Workers' Compensation

Accident State:  \*      State of Jurisdiction:  \*  
 Accident Location:  Employer  Lessee  Other \*  
 Drivers License #:       Drivers License State:  \*  
 Accident Description: (50 character limit)  \*  
 Claim Summary: (Include any relevant details)   
 Initial Medical Treatment:  
 None Required  Refused  First Aid Only  Physician/Treatment Facility Visit  Emergency Room Visit  
 Witnesses  
  
**Group/Analysis Codes**  
 Group Codes:      Cause:  
 OCCUPATION:  \*      Special Analysis 4:  
 TYPE:  \*      Special Analysis 5:  
 SUBCLASS:  \*  
**Workers' Compensation/Jones Act C**  
 Yes  No \*  
 Returned to Light Duty Date:  OR Returned to   
 Employee Died Because of Accident:  Yes  No \*  
 Zipcode Injury Site:  \*  
 Salary Continued in Lieu of Compensation:  Yes  No \*      Full Wages Paid Day   
 Employment:  \*      Hire Date:  \*

Special Analysis Codes:

- ACCIDENT - HIT AND RUN
- ADMINISTRATIVE DECISION
- ALL RISK
- ALLEGED NEGLIGENT ACT
- ANIMAL
- ANIMAL BITE / SCRATCH
- ANIMAL BITE / STING
- ARSON
- ASBESTOS
- ASSAULT - STUDENT VS STUDENT
- ASSAULT - TEACHERS VS STUDENT
- ASSAULT / BATTERY
- AT RISK
- ATHLETIC PARTICIPATION INJURY

Too many items were found and the list was cut off. Enter a filter below to alter the listing.

Select what is applicable

# Workers' Compensation

**Group/Analysis Codes**

Group Codes:      Special Analysis Codes:

OCCUPATION:  \*      Cause:  \*

TYPE:  \*

SUBCLASS:  \*

Special Analysis 4:

Special Analysis 5:

---

**Workers' Compensation/Jones Act Only**

Lost Time:  Yes  No \*

Date Last Worked:

Returned to Work:  Yes  No

Returned to Light Duty Date:       OR      Returned to Fulltime Date:

Employee Died Because of Accident:  Yes  No \*

---

Zipcode Injury Site:  \*

Salary Continued in Lieu of Compensation:  Yes  No \*      Full Wages Paid Day Injured:  Yes  No \*

Employment:  \*      Hire Date:  \*

Rate of Pay: \$  \*       Hourly  Daily  Weekly  BiWeekly  Semi-Monthly  Monthly  Annually \*

Job Code:       Job Title (Carrier):  \*

---

**Attachments**

You must click on a "Save" button below before you can add attachments.

---

**History**

Completed By:

Name:  \*

Title:

Phone:  \*

Created:

Last Changed:

Ready For Review:

RPO Submitted:

Claim Submitted:

School site zip code

Use \$1.00/weekly as rate of pay

# Workers' Compensation

**Group/Analysis Codes**

**Group Codes:**  
 OCCUPATION:  \*  
 TYPE:  \*  
 SUBCLASS:  \*

**Special Analysis Codes:**  
 Cause:  \*  
 Special Analysis 4:   
 Special Analysis 5:

---

**Workers' Compensation/Jones Act Only**

Lost Time:  Yes  No \*  
 Date Last Worked:   
 Returned to Work:  Yes  No  
 Returned to Light Duty Date:  OR Returned to Fulltime Date:   
 Employee Died Because of Accident:  Yes  No \*

---

Zipcode Injury Site:  \*  
 Salary Continued In Lieu of Compensation:  Yes  No \*  
 Full Wages Paid Day Injured:  Yes  No \*  
 Employment:  \*  
 Hire Date:  \*  
 Rate of Pay: \$  \*  Hourly  Daily  Weekly  BiWeekly  Semi-Monthly  Monthly  Annually \*  
 Job Code:  Job Title (Carrier):  \*

---

**Attachments**

You must click on a "Save" button below before you can add attachments.

---

**History**

Completed By:  
 Name:  \*  
 Title:   
 Phone:  \*

Created:  
 Last Changed:  
 Ready For Review:  
 RPO Submitted:  
 Claim Submitted:

# Workers' Compensation

**Workers' Compensation/Jones Act Only**

Lost Time:  Yes  No \*

Date Last Worked:

Returned to Work:  Yes  No

Returned to Light Duty Date:  OR Returned to Fulltime Date:

Employee Died Because of Accident:  Yes  No \*

---

Zipcode Injury Site:  \*

Salary Continued In Lieu of Compensation:  Yes  No \*      Full Wages Paid Day Injured:  Yes  No \*

Employment:  \*      Hire Date:  \*

Rate of Pay: \$  \*     Hourly  Daily  Weekly  Bi/Weekly  Semi-Monthly  Monthly  Annually \*

Job Code:       Job Title (Carrier):  \*

---

**Attachments**

You must click on a "Save" button below before you can add attachments.

---

**History**

Completed By Name: <input type="text" value="LOUISE CARPENTER"/> * Title: <input type="text"/> Phone: <input type="text" value="505-837-5766"/> *	Created: Last Changed: Ready For Review: RPO Submitted: Claim Submitted:
--	--

---

A \* next to a field means that it is required.

## Workers' Compensation

What is the difference in report status?

**Report Only** is a report that stays in the clients ICE system and hasn't been submitted to CCMSI. **NMPSIA wants ALL claims submitted to CCMSI. Please do not keep RPO claims in your system, submit the claim.**

**Incident Only** is a claim that has been submitted to CCMSI and is like a Report Only because the worker has **not** sought medical treatment.

**Medical Only** is a claim that has been submitted to CCMSI and has been activated to a Medical Only Adjuster because the worker is receiving medical treatment but has **not** been disabled more than the 7-day waiting period.

**Lost Time** is a claim that has been submitted to CCMSI and has been activated to a Lost Time Adjuster because the worker is receiving medical treatment and has been disabled more than the 7-day waiting period.



# Workers' Compensation

ICE NMPISA CCMSI

FAQ Log Out In-Progress Ready for Review Complete Search Create New Report

**Ready for Review Initial Report Forms**

Created	Last Updated	Name	Date of Loss	Coverage	Report Type	State of Jurisdiction	Accident Description	Location	Location2	
7/5/2018	7/12/2018		7/3/2018	WC	CLAIM	NM	Wrenched arm			X
5/22/2018	5/23/2018		5/22/2018	WC	CLAIM	NM	Hit in left eye with ball			X
4/30/2018	4/30/2018		4/30/2018	WC	CLAIM	NM	STUDENT BITE ON CHEST AREA			X
4/25/2018	4/25/2018		4/25/2018	WC	REPORT ONLY	NM	Hit by a student			X
4/25/2018	4/25/2018		4/25/2018	WC	REPORT ONLY	NM	Hit by a student			X
4/11/2018	4/11/2018		4/10/2018	WC	REPORT ONLY	NM	breaking up a fight			X
3/28/2018	3/28/2018		3/28/2018	WC	CLAIM	NM	Hit by student on shoulder			X
3/28/2018	3/28/2018		3/27/2018	WC	CLAIM	NM	Hit by student on R shoulder			X
3/28/2018	3/28/2018		3/20/2018	WC	CLAIM	NM	Hit by student in L shoulder			X
3/23/2018	3/23/2018		3/21/2018	WC	CLAIM	NM	Smashed finger in door			X
3/21/2018	3/21/2018		3/21/2018	WC	CLAIM	NM	Smashed finger in door			X
3/9/2018	3/9/2018		3/9/2018	WC	REPORT ONLY	NM	Burned arm with hot cheese			X
1/29/2018	3/9/2018		1/26/2018	WC	REPORT ONLY	NM	tripped fell on knees & right arm			X
3/1/2018	3/6/2018		2/28/2018	WC	REPORT ONLY	NM	Lifted trash, felt a pain go up left arm to neck			X
2/28/2018	2/28/2018		2/23/2018	WC	REPORT ONLY	NM	Fell on back during field trip			X
2/7/2018	2/7/2018		2/6/2018	WC	CLAIM	NM	Fell on right knee, causing pain			X
2/5/2018	2/6/2018		2/5/2018	WC	CLAIM	NM	Student was scratching arm, back, stomach			X
2/5/2018	2/5/2018		2/5/2018	WC	CLAIM	NM	Autism Student scratching on neck, side of stomach			X
10/25/2017	11/15/2017		10/25/2017	WC	CLAIM	NM	seperating a fight hurt my knee			X
10/13/2017	10/13/2017		10/13/2017	WC	CLAIM	NM	breaking up a fight i was thrown back and fell			X

Home  
Executive Summary  
Claims Analysis  
Initial Reports  
Report Delivery  
OSHA  
Loss Control  
Client  
Change Client  
Lookup Claim By:  
Claimant Name  
Last, First Go  
Logged In As:  
Louise Carpenter  
Your session expires in 29 minutes  
Reset  
Set As Default Page  
ICE Administration  
Portal Options  
Websites  
ICE Help  
Interactive Help  
User Guides (PDF)  
Help Desk

# Workers' Compensation

ICE NMPSIA CCM

FAQ Log Out In-Progress Ready for Review Complete Search Create New Report

**Completed Initial Report Forms**  
(20 Most Recent or Last 3 Months)

Created	Last Updated	Name	Claim Number	Date of Loss	Coverage	Report Type	State of Jurisdiction	Accident Description	Location	Location2
6/4/2018	7/26/2018		RPO_F689836	06/04/2018	WC	REPORT ONLY	NM	metal from desk cut finger		
6/27/2018	7/26/2018		RPO_F689834	06/27/2018	WC	REPORT ONLY	NM	Fell off 3 foot ladder stepping down Rm. 314 at Y		
7/17/2018	7/26/2018		RPO_F689763	07/16/2018	WC	REPORT ONLY	NM	slipped and fell - hurt left wrist and butt		
7/25/2018	7/26/2018		18H01F689761	07/13/2018	WC	CLAIM	NM	Inhalation of concrete dust and propane fumes		
7/25/2018	7/25/2018		18H01F689640	05/04/2018	WC	CLAIM	NM	PACKING EQUIP. FELL AND CUT L PINKY		
7/24/2018	7/24/2018		18H01F689341	07/23/2018	WC	CLAIM	NM	stepped arong & fell in hallway		
7/24/2018	7/24/2018		18H01F687887	07/16/2018	WC	CLAIM	NM	FLOOR BUFFER DEFECTIVE HURTING SHOULDER/LOWER BACK		
7/23/2018	7/23/2018		18H01F689802	07/11/2018	WC	CLAIM	NM	slipped on water hurt knee and foot		
7/20/2018	7/20/2018		18H01F685550	07/20/2018	WC	CLAIM	NM	Lifting heavy grabage into dumpster		
7/19/2018	7/19/2018		18H01F685241	07/18/2018	WC	CLAIM	NM	eye irritaion - soap		
7/19/2018	7/19/2018		18H01F684634	07/12/2018	WC	CLAIM	NM	hit right upper arm		
7/17/2018	7/17/2018		18H01F683220	07/09/2018	WC	CLAIM	NM	smashed hand		
7/17/2018	7/17/2018		18H01F682942	07/19/2018	WC	CLAIM	NM	student bit (R) Forearm		
7/16/2018	7/16/2018		18H01F682356	07/16/2018	WC	CLAIM	NM	CLEANING BOARD GOT SPRAYED IN FACE		
7/12/2018	7/12/2018		18H01F679650	06/21/2018	WC	CLAIM	NM	While carrying dirt strained back		
7/11/2018	7/11/2018		18H01F679215	07/11/2018	WC	CLAIM	NM	Slipped, fell on floor		
7/11/2018	7/11/2018		18H01F678911	07/10/2018	WC	CLAIM	NM	cutting melon and cut right index finger		
7/11/2018	7/11/2018		18H01F678672	07/09/2018	WC	CLAIM	NM	Moving filing cabinet		
5/7/2018	7/10/2018		18H01F594923	05/07/2018	WC	CLAIM	NM	Cut finger		

Home  
Executive Summary  
Claims Analysis  
Initial Reports  
Report Delivery  
OSHA  
Loss Control  
Client  
Change Client

Lookup Claim By:  
Claimant Name  
Last, First Go

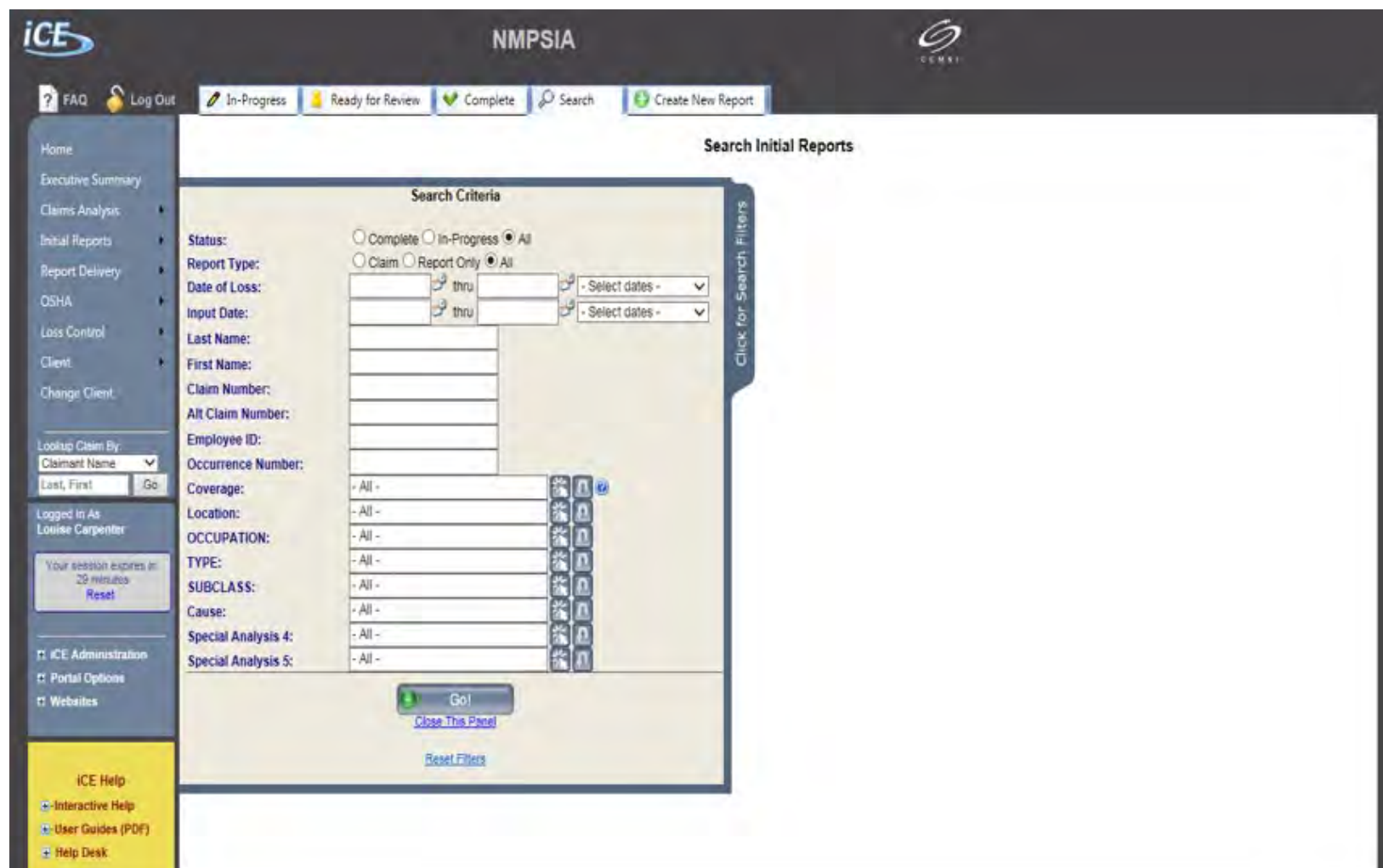
Logged In As  
Louise Carpenter  
Your session expires in: 23 minutes  
Reset

Set As Default Page

ICE Administration  
Portal Options  
Websites


ICE Help  
Interactive Help  
User Guides (PDF)  
Help Desk

# Workers' Compensation



The screenshot displays the iCE NMPSIA web application interface. At the top, there are navigation links for FAQ, Log Out, In-Progress, Ready for Review, Complete, Search, and Create New Report. The main content area is titled "Search Initial Reports" and contains a "Search Criteria" form. The form includes various search filters such as Status (Complete, In-Progress, All), Report Type (Claim, Report Only, All), Date of Loss, Input Date, Last Name, First Name, Claim Number, Alt Claim Number, Employee ID, Occurrence Number, Coverage, Location, OCCUPATION, TYPE, SUBCLASS, Cause, Special Analysis 4, and Special Analysis 5. A "Go" button is located at the bottom of the search criteria section. On the left side, there is a sidebar menu with options like Home, Executive Summary, Claims Analysis, Initial Reports, Report Delivery, OSHA, Loss Control, Client, and Change Client. Below the menu, there is a "Lookup Claim By:" section with a dropdown menu for "Claimant Name" and a "Go" button. A session expiration warning is also visible, stating "Your session expires in: 29 minutes" with a "Reset" button. At the bottom of the sidebar, there is an "ICE Help" section with links for Interactive Help, User Guides (PDF), and Help Desk.

# Workers' Compensation

 Monday, July 02, 2018
CCARPENTER [Log Out](#)

Current Claim: (F589395) Baca, Sandra - DOL: 4/20/2018 12:00:00 AM

Limit to State of Jurisdiction

Form Group

- ACORD Forms
- Comp MC Forms
- Excess Carrier Forms
- Form Letters
- New Mexico State Forms
- OSHA
- USLH Forms

Available Forms

- EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS - NM-E1 PDF
- NOTICE OF BENEFIT PAYMENT - NM-E6.pdf

**Split-Pane View** This option will allow the user to view the data entry grid and see the PDF image at the same time. Direct data entry to the PDF form is prohibited.


**Single-Pane View** This option will show you the data entry grid and the associated PDF form independently. Data may be entered directly on the redereed PDF, but directly entered data on the PDF is not saved!

Get Form

Instructions:

1. Select a State or Form Group.
2. Select the desired form to fill out.
3. Click the 'Get Form' button to proceed.

This application requires the Adobe Acrobat Reader to view the completed forms.



CCMSI—CCMSI FormFiller Application
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# Workers' Compensation



The screenshot shows the CCMST FormFiller application interface. At the top left is the CCMST logo. The header text reads "FormFiller | Enter Form Fields". Below the header is a navigation bar with the date "Wednesday, December 16, 2009" and a "Log Off" link. The main content area displays the form title "NM - EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS [7/02 ]". A red message states: "Previously entered FormFiller data exists from 12/16/2009 5:21:56 PM. Do you want to use the saved form data?". Below this message are two buttons: "Yes, Use Saved Data" and "No, Reset Data to Original". A black arrow points to the "Yes, Use Saved Data" button. A grey callout box with the text "Click on Yes, Used Saved Data" is positioned over the arrow. The footer contains the text "CCMSI—CCMSI FormFiller Application" on the left and "Copyright 2005 CCMST. All rights reserved." on the right.

# Workers' Compensation

Friday, July 27, 2018 CCARPENTER [Log Out](#)

**NM - EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS [7/02]**  
Help Guide

Refresh PDF Save Data Download PDF Attach To Claim Notes Cancel

**FormFiller Color Key**

Color Code	Description
Gold background	Indicates field is <b>not</b> currently captured from Toolbar or iCE. Any value entered into these fields will be saved in FormFiller. If the 'Use Saved Data' button is selected on a Future FormFiller session, these fields will populate from the saved values.
No background color	Indicates field is available and will be populated from Toolbar or iCE values. If the 'Use Saved Data' button is selected on a future FormFiller session, these fields will populate from the current Toolbar values, or from the FormFiller saved data if the Toolbar values have not yet been populated.

Complete or change the form fields below and click one of the buttons to continue.

Form Fieldname	Value
<b>EMPLOYER NAME</b>	CENTRAL CONSOLIDATED SCHOOLS
<b>EMPLOYER STREET</b>	583 COUNTY ROAD 6100
<b>EMPLOYER CITY/STATE/ZIP</b>	KIRTLAND, NM 87417
<b>Phone Number</b>	
<b>Employer FEIN</b>	85600095
<b>Carrier/Administrator Claim Number</b>	17H01F280941
<b>OSHA Log</b>	
<b>Report Purpose Code</b>	

Print PDF 1 / 1 66.2% Tools Sign Comment

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**  
**EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS**

2410 CENTRE AVE. SE • PO BOX 27198  
ALBUQUERQUE, NM 87125-7198

THIS REPORT IS TO BE FILED IN THE STATE OF NEW MEXICO

<b>EMPLOYER (NAME &amp; ADDRESS (NO. ZIP))</b> CENTRAL CONSOLIDATED SCHOOLS 583 COUNTY ROAD 6100 KIRTLAND, NM 87417	<b>CARRIER-ADMINISTRATOR CLAIM #</b> 17H01F280941	<b>OSHA LOG NUMBER</b>	<b>REPORT PURPOSE CODE</b>
<b>EMPLOYER STREET</b>	<b>EMPLOYER CITY</b>	<b>EMPLOYER STATE</b>	<b>EMPLOYER ZIP</b>
<b>PHONE NUMBER</b>	<b>EMPLOYER FEIN</b> 85600095	<b>EMPLOYER LOCATION ADDRESS (IF DIFFERENT)</b>	<b>LOCATION</b>
<b>CARRIER (NAME, ADDRESS &amp; PHONE NO.)</b>	<b>POLICY PERIOD</b> TO: 2017	<b>CLAIM ADMINISTRATOR (NAME, ADDRESS &amp; PHONE NO.)</b>	<b>CLAIM ADMINISTRATOR PHONE NO.</b>
<b>CARRIER FEIN</b>	<b>POLICY IDENTIFICATION NUMBER</b> SP405500	<b>EMPLOYER LOCATION</b>	<b>EMPLOYER CITY</b>
<b>AGENT NAME &amp; CODE NUMBER</b>	<b>NAME (LAST, FIRST, MIDDLE)</b> TPSE	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY NUMBER</b>
<b>EMPLOYEE INFORMATION</b>	<b>DATE OF BIRTH</b>	<b>STATE OF BIRTH</b>	<b>STATE OF HIRE</b>
<b>ADDRESS (INCLUDE ZIP)</b>	<b>SEX</b> <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE	<b>MARRIAGE STATUS</b> <input type="checkbox"/> UNMARRIED <input type="checkbox"/> MARRIED	<b>OCCUPATIONAL STATUS</b> COLLEGE PROF EMP/CLER
<b>PHONE NUMBER</b>	<b>EMPLOYMENT STATUS</b> <input type="checkbox"/> HOURS <input type="checkbox"/> SEASONAL <input type="checkbox"/> UNKNOWN	<b>EMPLOYMENT DATE</b>	<b>EMPLOYMENT TYPE</b> Full Time
<b>DATE</b>	<b>DATE OF OCCURRENCE</b> 08/02/2017	<b>DATE EMPLOYER NOTIFIED</b> 08/02/2017	<b>DATE EMPLOYEE FILED</b>
<b>TIME EMPLOYEE BEGAN WORK</b>	<b>TIME OF OCCURRENCE</b> 11:00	<b>DATE EMPLOYER NOTIFIED</b>	<b>DATE EMPLOYEE FILED</b>
<b>CONTACT NAME &amp; PHONE NUMBER</b>	<b>TYPE OF INJURY/ILLNESS</b> MULTIPLE INJURIES - MULTIPLE B	<b>TYPE OF BODY PARTS - M</b>	<b>TYPE OF BODY PARTS - F</b>
<b>OSHA LOG NUMBER</b>	<b>TYPE OF INJURY/ILLNESS CODE</b> 90	<b>TYPE OF BODY PARTS CODE</b>	<b>TYPE OF BODY PARTS CODE</b>
<b>OSHA LOG NUMBER</b>	<b>TYPE OF INJURY/ILLNESS CODE</b>	<b>TYPE OF BODY PARTS CODE</b>	<b>TYPE OF BODY PARTS CODE</b>
<b>OSHA LOG NUMBER</b>	<b>TYPE OF INJURY/ILLNESS CODE</b>	<b>TYPE OF BODY PARTS CODE</b>	<b>TYPE OF BODY PARTS CODE</b>

CCMSI—CCMSI FormFiller Application
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# Workers' Compensation

**Scroll down to ensure data is correct, if so, hit save & then hit print.**

NM - EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS [7/02] Log Out

Help Guide

Refresh PDF **Save Data** Download PDF Attach To Claim Notes Cancel

FormFiller Color Key	
Color Code	Description
Gold background	Indicates field is <b>not</b> currently captured from Toolbar or iCE. Any value entered into these fields will be saved in FormFiller. If the 'Use Saved Data' button is selected on a Future FormFiller session, these fields will populate from the saved values.
No background color	Indicates field is available and will be populated from Toolbar or iCE values. If the 'Use Saved Data' button is selected on a future FormFiller session, these fields will populate from the current Toolbar values, or from the FormFiller saved data if the Toolbar values have not yet been populated.

Complete or change the form fields below and click one of the buttons to continue.

Form Fieldname	Value
EMPLOYER NAME	CENTRAL CONSOLIDATED SCHOOLS
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EMPLOYER CITY/STATE/ZIP	KIRTLAND, NM 87417
Phone Number	
Employer FEIN	85600095
Carrier/Administrator Claim Number	17H01F280941
OSHA Log	
Report Purpose Code	

Print 1 / 1 66.2% Tools Sign Comment

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**  
**EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS**

2410 CENTRE AVE. SE • PO BOX 27198  
ALBUQUERQUE, NM 87125-7198

FF FORM 0001 (REV. 06/07) (REV. 02/10)

<b>G E N E R A L</b>	EMPLOYER (NAME & ADDRESS (incl. ZIP))		CARRIER/ADMINISTRATOR CLAIM #	DATE OF OCCURRENCE	REPORT PURPOSE CODE
	CENTRAL CONSOLIDATED SCHOOLS 583 COUNTY ROAD 6100 KIRTLAND, NM 87417		17H01F280941	NM	961305
<b>C A R R I E R</b>	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD:	CLAIM ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)	
			1/1/2017 - 12/31/2017	CCMSI	
<b>E M P L O Y E E</b>	EMPLOYEE (NAME & ADDRESS (incl. ZIP))		DATE OF BIRTH	SOURCE SECURITY NUMBER	DATE OF HIRE
					3/2005
<b>P E R S O N A L</b>	PERSONAL INFORMATION		SEX	EDUCATION	OCCUPATIONAL TITLE (OR BODY CODE)
			MALE	UNEMPLOYED	COLLEGE PROF EMP/CLC
<b>W O R K I N G</b>	EMPLOYMENT INFORMATION		EMPLOYMENT STATUS	EMPLOYMENT STATUS	EMPLOYMENT STATUS
			Full Time		
<b>T I M E</b>	DATE		MONTHS WORKING	ALL PART FOR PERCENT OF FULLTIME	PERCENT OF FULLTIME
			0		
<b>D E T A I L S</b>	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
	MULTIPLE INJURIES - MULTIPLE BODIES		MULTIPLE BODY PARTS - M		
<b>R E M A R K S</b>	ALL EQUIPMENT, MATERIALS, TOOLS OR MACHINES OF VALUE OR DAMAGE EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN AT ACCIDENT OR EXPOSURE OCCURRED		

CCMSI—CCMSI FormFiller Application

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## Workers' Compensation

If you get **locked out** of the system  
Please contact our help desk at

1-888-578-5555 x8062

Have your ID ready so they can reset  
your password.

## NMPSIA Rules & Regulations

**6.50.14.8 WORKERS' COMPENSATION CLAIM POLICY: All school districts, charter schools, other educational entities and any other entities participating in the authority's workers' compensation coverages shall adopt a workers' compensation claim policy for its employees substantially in the form as set forth in Subsections A through I of 6.50.14.9 NMAC, selecting one of two options available for the selection of health care providers, for use of sick leave and for payment of insurance premiums while an employee is disabled from work. The form policy is also downloadable from the authority's website at: <https://nmpsia.com> and will be updated from time to time. [6.50.14.8 NMAC - Rp, 6 NMAC 50.14.8, 09/01/2014]**

# Workers' Compensation

## Claims Workbook:

General information about reporting, investigating and managing Workers' Compensation Claims can be found in the

[Workers' Compensation and Property & Liability Claims Workbook \(fillable PDF\)](#)

## Workers' Compensation Forms & Documents

Forms

Sample Workers' Compensation Policy Options

- Workers' Compensation Policy Option 1
- Workers' Compensation Policy Option 2
- Workers' Compensation Policy Option 3
- Workers' Compensation Policy Option 4

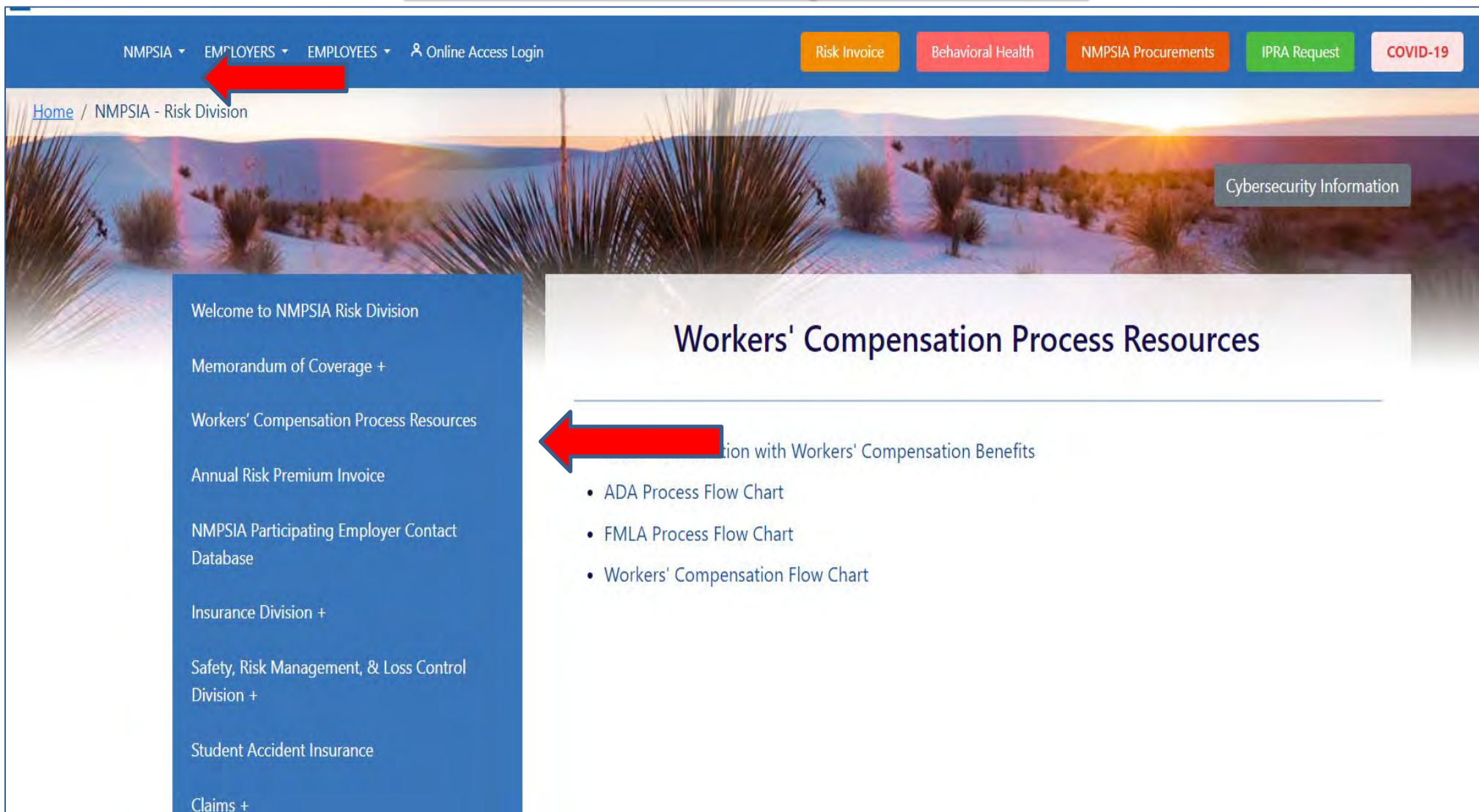


# Workers' Compensation

## EXAMPLE WORKERS' COMPENSATION POLICY – OPTION 4

- Worker Selects Initial Health Care Provider;
- Injured Worker may use Leave (Sick, Vacation, or PTO) until Accumulated Leave has been Exhausted;
- Injured Worker is allowed to have their Portion of Insurance Premiums, Retirement Contributions, etc., deducted from Payments of their Accumulated Leave until the Accumulated Leave has been Exhausted.

# Workers' Compensation



NMPSIA ▾ EMPLOYERS ▾ EMPLOYEES ▾ Online Access Login

Risk Invoice Behavioral Health NMPSIA Procurements IPRA Request COVID-19

Home / NMPSIA - Risk Division

Cybersecurity Information

Welcome to NMPSIA Risk Division

Memorandum of Coverage +

Workers' Compensation Process Resources

Annual Risk Premium Invoice

NMPSIA Participating Employer Contact Database

Insurance Division +

Safety, Risk Management, & Loss Control Division +

Student Accident Insurance

Claims +

## Workers' Compensation Process Resources

ation with Workers' Compensation Benefits

- ADA Process Flow Chart
- FMLA Process Flow Chart
- Workers' Compensation Flow Chart

# Workers' Compensation

https://www.nmsba.org/policy-service/



ABOUT NMSBA   EVENTS   ADVOCACY   SERVICES   RESOURCE CENTER   AWARDS   CONTACT NMSBA

## POLICY SERVICE

Go to Policy Service Portal



How to Search a Policy Manual

New Mexico Policy Service Program Summary

- The program provides enhanced policy services on a four year subscription basis supervised by a licensed New Mexico Attorney with over 30 years policy writing experience.
- Policies are updated periodically as changes in statutory law, case law, state agency rules and regulations, Attorney General Opinions, and local conditions and circumstances occur.
- Features of the Policy Services Program include:
  - A national system for coding and retrieving policy, developed by the National School Boards Association.
  - On call or e-mail to discuss policy related issues and possible revisions. With appropriate topically-related information, Policy Services will write personalized policy for the District.
- Secured Internet access to the District Policy Manual for the public and staff using browsers commonly available on computers.
- The assistance provided by the Policy Services Program reduces the amount of time devoted to review and documentation of state and federal compliance issues.

Search ...

SEARCH

### NMSBA NEWS BRIEFS

NMSBA announces it's new Superintendent Search Service cadre

NMSBA Now Posts Superintendent Vacancies

Master Board Member Program

Past Conferences and Region Meetings

Governor Michelle Lujan Grisham tops list of Keynote Speakers at NMSBA Board Institute

# Workers' Compensation

lp.ctspublish.com/nm/



Please select the desired district below

Select here

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- Animas Policy Manual
- Artesia Policy Manual
- Aztec Policy Manual
- Belen Policy Manual
- Bernalillo Policy Manual
- Bloomfield Policy Manual
- Capitan Policy Manual
- Carlsbad Policy Manual
- Carrizozo Policy Manual
- Central Policy Manual
- Chama Policy Manual
- Cimarron Policy Manual
- Clayton Policy Manual
- Cloudcroft Policy Manual
- Clovis Policy Manual
- Cobre Policy Manual
- Cuba Policy Manual
- Des Moines Policy Manual

# Workers' Compensation




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- G-1400 © GBGCA WELLNESS PROGRAI
- G-1431 © GBGCA-E
- G-1500 GBGD WORKERS' COMPENSA ←

 **G-1500 GBGD  
WORKERS' COMPENSATION**

All employees are covered under the provisions of Workers' Compensation for occupational injuries and illnesses in accordance with the provisions of New Mexico Law (Work Compensation Act, Chapter 52, NMSA 1978). The School District utilizes a self-directed care approach to Workers' Compensation. Procedures to report an on-the-job injury  
Workers' Compensation Benefits are available from the office secretary, principal or the Human Resources Department.

Adopted: date of manual adoption

LEGAL REF.:

[6.50.3.9 NMAC](#)

[6.50.14.9 NMAC](#)


CROSS REF.:


[EBBB](#) - Accident Reports



# Workers' Compensation

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- G-1650 @ GBJ PERSONNEL RECORDS, I
- G-1790 @ GBJC EMPLOYMENT RECOM
- G-1791 GBJC-R
- G-1800 @ GBK STAFF GRIEVANCES

 **G-1511** © GBGD-R

**REGULATION**

**WORKERS' COMPENSATION**

Any employee who has an accident while on duty shall notify the supervisor immediately and the appropriate reporting is to be completed within seventy-two (72) hours. Failure to follow this procedure could result in the loss of workers' compensation benefits.

When a job-related injury/accident requires medical attention and absence from the workplace, the following conditions shall apply:

- The day of injury is considered as a full day worked; no sick leave will be charged regardless of time of injury if employee seeks medical treatment.
- An employee is to utilize accumulated sick leave for the initial seven-day period (normally five working days).
- After the initial seven (7) days, employees retain the compensation received from Workers' Compensation and do not use any of their accumulated sick leave for the time they are absent from work and for which they have received compensation.
- At this time the employee will be placed on leave without pay.
- If you miss more than twenty-eight (28) days, Workers' Compensation will reimburse the first seven (7) days at your workers' compensation benefit rate.

The weekly compensation rate to the employee by Workers' Compensation for total disability is 66 2/3% of the employee's average weekly gross earnings subject to the maximum specified by law.

In order to continue current personal insurance benefits (health, dental, etc.), it will be necessary for the employee to pay directly to Alamogordo Public Schools the amount of his/her payroll deduction for insurance premiums once he/she has been removed from the payroll to be placed on Workers' Compensation leave of absence. The premium payment will be due in the School District offices on or before the first working day of each month. The School District will continue payment of the Board's portion of this insurance premium while the employee is under contract.


The Alamogordo Public Schools will require an "Employee's Statement of Health" for all new employees.

# Workers' Compensation


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- G-1791 GBJC-R
- G-1800 @ GBK STAFF GRIEVANCES
- G-1811 GBK-R



 **G-1531 GBGD-E**

**EXHIBIT**

**WORKERS' COMPENSATION**

(Return to Work - Modified Duty)

**Scope**

This policy applies to District employees who have duty restrictions resulting from a work-related injury or illness. It does not apply to restrictions resulting from non-work related events or conditions. While modified duty opportunities will be offered to the maximum extent possible, there is no guarantee, express or implied, that such duty will be available in every case.

**Objective**

The objective of this policy is to minimize workers' compensation costs by, where possible, providing a temporary, modified duty assignment for employees who have been injured on the job in order to facilitate an early return to work or to permit the employee to remain on the job in a productive capacity. Each principal/supervisor must make efforts to make available modified duty assignments for employees who have been released by their physician to return to work following a work-related injury or illness.

**Eligibility**

In order for an employee to be eligible for a temporary modified duty assignment:

- The injury must be work-related;
- The injury must be temporary and not be expected last longer than 45 calendar days from the date of injury;
- The employee must provide medical documentation from the treating physician prescribing specific work restrictions and anticipated duration of the limiting injury;
- The employee must be willing to perform his or her modified duty assignment with care and diligence.

**Requesting Modified Duty**

# Workers' Compensation



# WHY WELLNESS?



# WHY WELLNESS?

## Top 5 Reasons Why Wellness is a Priority:

- 1) Prevention and early detection of chronic diseases
- 2) Promotes Safety- Reduces Overall Costs of Worker's Compensation claims
- 3) Creates High Performing Employees, Improves Productivity
- 4) Increased Personal Responsibility Improves unhealthy behaviors
- 5) Stabilizes Insurances Costs!





New Mexico  
Public Schools  
Insurance  
Authority



NMPSIA  
Wellness



# Leadership & Culture



Organizations with supportive leadership are **4x** more likely to report substantial improvement in employee health risk and **2.5x** more likely to report substantial improvement in medical costs

## Make a Difference

**Leadership** engagement at all levels:

- shapes workplace climate
- drives employee participation
- inspires personal accountability
- promotes sustainable success

**An Effective Workplace Strategy:**

- Incorporates wellness into company mission, vision and values
- Modifies management strategies to articulate “culture of health”
- Translates vision into clear action
- Engages leaders at all levels



# The State of Worksite Wellness



Incorporating **cultural elements** in wellness strategies results in a reduction of employee health risks 2.5 times that of standard practices.

**5%**  
per year



**56%** of employers believe their current health & wellbeing programs encourage employees to live a healthier lifestyle, **but just 32% of employees agree.**



Many employees are dissatisfied with their Employer Wellness Programs.

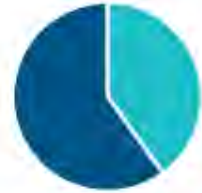
**61%**  
in 2017



**11%** When payers address social determinants of health.  
cost decrease

## Impact of Culture

- Programs have been shown to affect 40% of employees; **company culture impacts 100% of employees**
- Establishing **policies to positively influence** social and economic conditions supports changes in individual behavior; this **can improve health for large numbers of people** in a way that can be sustained over time
- Research shows that **stocks** of companies with award-winning health programs outperform the market average
- A recent U.S. study found **physically active adults have lower annual health care expenditures** than insufficiently active adults which are associated with 11.1% of total health care expenditures
- **53%** of organizations want to create a culture that promotes health and wellness, with **60%** of organizations offering wellness programs (in 2017)



# Wellness Pulse Check Survey

## Wellness Pulse Check™ evaluates, measures and scores:

- Employer lead survey
- Addresses Organizational wellness efforts and employee experiences
- Provides scoring for each question and module
- “Wellness Pulse” score provides benchmark for key wellness efforts
- Generates actionable insights and programming ideas for a personalized wellness recommendations
- Turnkey design to reach entire employee population





“A strong **culture of health** has emerged as a strategic imperative for helping to drive better results for improved health and wellbeing, workforce performance and cost control across an organization.”



The  
Solutions  
Group



New Mexico  
Public Schools  
Insurance  
Authority



**NMPSIA**  
*Wellness*

# Wellness Ambassadors

# What is a well-being ambassador?

- **Role models** who inspire and encourage others.
- **Accelerators** who can quickly spread the word and increase engagement.
- **On-the-ground connectors** of people with ideas and opportunities.

## A Wellness Ambassador is part of a champion network

A diverse group of employees who serve as the communicators, motivators, promoters, & leaders of your well-being goals, strategies, & programs.



The secret weapon for bringing well-being strategy to life



**YOU are the secret weapon!**

# The benefits of an organized Wellness Ambassador network

- Leverage social connections.
- Accelerate adoption and engagement.
- Gain valuable feedback.
- Provides a self-development opportunity for ambassadors.

**Ambassadors can help create and enhance a culture of well-being in the workplace.**





# Keep it fun! Promote creative sharing

- **Collaborate** and encourage wellness ambassadors to offer suggestions and provide feedback.
- Give or share **ownership** wherever possible.
- **Celebrate** progress.



# Wellness Ambassadors

## NMPSIA



**Interested in becoming an Ambassador?  
Scan the QR code to apply now!**



Once your application is approved, you will receive a Nike Backpack with the NMPSIA Wellness Logo!

Questions? Email [NMPSIA.WELLNESS@phs.org](mailto:NMPSIA.WELLNESS@phs.org).

# Lunch & NMPSIA Jeopardy

## 12:00 – 12:30

### Coming up:

**12:30 p.m.      How to be a Smart Consumer - Martha Quintana**

**1:00 p.m.      Required Online Enrollment - Kathy Payanes**

- Employer:  
New Hire (Basic Life), Cancel EE, Report LOA (Return and Change Date)
- Employee:  
Change Beneficiary, Open/Switch (change enrollment), Change Basic Info



# New Mexico Public Schools Insurance Authority

## NMPSIA 2023 Regional Training Benefits Smart Consumer

# Employee Benefits

## Wellness & Well-Being Programs

NMPSIA offers the following benefits:

Self Insured Medical Options



BlueCross BlueShield  
of New Mexico



**PRESBYTERIAN**  
Health Plan, Inc.

Self-Insured Prescription Drug Coverage



Self-Insured High & Low Option Dental Plans



Fully Insured Vision Plan



DavisVision™

Fully Insured Life & Disability Plan

Wellness & Well-Being Program



- Discounted Gym Memberships
- Member Wellness & Well-Being Strategic Planning
- Member Health and Wellness Onsite Events, Screenings, and Activities

Customer Service

- Claim Issues and Reconsideration of Enrollment Determinations

Employer Benefits Administration



Easa Administrative Services, Inc.

- Support with Enrollment, Billing and Premium Collection
- COBRA Administration

Program Guide & Medical Plan Side-By-Side Comparison

Visit <https://nmpsia.com>

# In-Network Medical Plan

## HIGH OPTION MEDICAL PLAN

- \$25 copay for office visits
- \$50 copay for specialist office visit
- \$0 copay for Telehealth virtual video visits (access via carrier website)
- \$0 Routine annual wellness visits
- Deductible waived for in-network lab and radiology
  - \$30 copay when using free-standing labs or radiology facilities
  - **More expensive at out-patient hospital labs (\$60 copay)**
    - No charge for Professional Interpretation/Reading of lab and radiology
  - \$600 copay or 20% (*whichever is less*) for MRI, MRA, CT Scan, Pet Scan
- **\$750 Individual Deductible and 20% coinsurance**
- \$4,100 Individual Calendar Year Maximum for covered services (*copays, deductible, coinsurance*)
- **Out of network benefits at 40% coinsurance after \$1,500 individual deductible**

Visit <https://nmpsia.com/> to view benefit summaries and side-by-side medical plan comparison chart

# In-Network Medical Plans



## LOW OPTION MEDICAL PLAN – “catastrophic plan”

- \$30 copay for office visits
- \$60 copay for specialist office visit
- \$0 copay for Telehealth virtual video visits (access via carrier website)
- \$0 Routine annual wellness visits
- **\$2,000** Individual Deductible and **25% coinsurance**
- \$4,100 Individual Calendar Year Maximum for covered services  
(*copays, deductible, coinsurance*)
- Out of network benefits at 50% coinsurance after \$4,000 individual deductible

## EPO Plan – Narrow NM Network



- \$25 copay for office visits
- \$35 copay for specialist office visit
- \$0 copay for Telehealth virtual video visits access (via carrier website)
- \$0 Routine annual wellness visits
- \$500 Individual Deductible
- \$3,250 Individual Calendar Year Maximum for covered services  
(*copays, deductible, coinsurance*)
- No out of network benefits except in an emergency

# Wellness Benefits

## No Cost to Members

- Medical Carrier Online Wellness Portals
  - Personal Health Assessments
  - Sync Health Devices
  - Wellness Topic & Resources
- Monthly Wellness and Well-being Resources and Events
- Newsletters & Mailers
- Health Coaching & Disease Management Outreach
- Mindfulness Based Stress Reduction Subscription
- Resiliency Program
- Weight Loss Programs
- Free Glucose Monitors
- Incentive Rewards (online shops & gift cards)
- Fitness Challenges
- Ergonomic Programs
- Virtual Cooking Demonstrations
- On-Site Health & Wellness Presentations
- Wellness Grant Opportunities
- Information found at NMPSIA Website – <https://nmpsia.com/>



WonderHealth



MotivateMe





# Prescription Drug Coverage

## Automatically enrolled when you enroll in medical coverage

- Rx ID card issued by CVS Caremark
- Formulary - <https://nmpsia.com/> (*Check for updates each quarter*)
- Generics
  - \$10 copay for 30 day supply at the pharmacy
  - \$22 copay for 31-90 day supply at the pharmacy
  - \$22 copay for 90 day supply via mail-order
- Preferred Brand-Name
  - 30% coinsurance (\$30 min/\$60 max) for 30 day supply at the pharmacy
  - \$60 copay for 31-90 day supply at the pharmacy
  - \$60 for 90 day supply via mail-order
- 70% coinsurance for non-formulary brand name drugs
- **\$0 Generic & Preferred Diabetic Supplies & Injectable Diabetic Medications**
- \*Specialty Medications - \$55 Generic; \$80 Preferred; \$130 Non-Preferred
- \$3,000 Individual Calendar Year Maximum for High & Low Option medical plans
- **\$3,100 Individual Calendar Year Maximum for EPO Option medical plan**



**Transform Diabetes Care® (TDC) offers extra support to manage diabetes at no cost to the member providing digital tools, blood glucose meter, blood pressure monitor and access to a minute clinic**



\* Your plan includes the PrudentRx program for certain eligible specialty medications exclusively dispensed by CVS Specialty. For these medications, 30% coinsurance will apply. If you are enrolled in PrudentRx, your final out of pocket cost will be \$0. If you opt out of PrudentRx, you will be responsible for the 30% coinsurance. Note: only the amount you pay out of pocket will be reflected in your annual deductible and/or maximum out-of-pocket.

# In-Network Dental Coverage

## High Option

- \$0 Diagnostic & Preventive Services (*Deductible waived*)
  - Routine Oral Exams (twice every calendar year)
  - Routine Cleanings (twice every calendar year)
  - Periodontal Cleanings (twice every calendar year)
  - X-rays - complete mouth (once every 5 years);
    - bitewings (twice every calendar year through age 13, once every calendar year thereafter)
- 20% Coinsurance for Basic Services
- 50% Coinsurance for Major Services & Orthodontic Services
- \$50 Individual Deductible for Basic and Major Services
- \$1,500 Calendar Year Maximum
- \$1,500 *Lifetime* Maximum for Orthodontics
- Out of network benefits at 45% - 65% coinsurance after deductible

List of NM contracted dentists for each carrier can be found at <https://nmpsia.com/>

# In-Network Dental Coverage

## Low Option

- \$0 Diagnostic & Preventive Services (*Deductible waived*)
  - Routine Oral Exams (twice every calendar year)
  - Routine Cleanings (twice every calendar year)
  - Periodontal Cleanings (twice every calendar year)
  - X-rays - complete mouth (once every 5 years);
    - bitewings (twice every calendar year through age 13, once every calendar year thereafter)
- 20% Coinsurance for Basic Services
- **NO Major Services or Orthodontic Services**
- \$50 Individual Deductible for Basic Services
- \$1,500 Calendar Year Maximum
  
- Out of network benefits at 75% coinsurance after deductible

List of NM contracted dentists for each carrier can be found at <https://nmpsia.com/>

# Vision Coverage

## Vision Plan

- \$10 copay Eye Exam (covered every 12 months from last date of service)
- \$15 copay Spectacle Lenses (standard single-vision, lined bifocal, or trifocal lenses - covered every 12 months from last date of service)
- Frames (covered every 24 months)
  - Additional discounted Lens options & coatings
- Contacts (covered every 12 months)
  - Order contact replacement lenses online
- *Be sure to ask to see the Davis Vision Frame and Contact collection*
- Includes discounts for Lasik and hearing aids
- Locate contracted providers – nationwide at <https://davisvision.com/>

# Life & Long-Term Disability Coverage

## Basic Life and Accidental Death & Dismemberment (AD&D)

- Employer chooses benefit level (\$10,000; \$25,000; \$50,000)

## Additional Life and AD&D

- Employee Life and AD&D – employee chooses 1, 2, or 3 times base annual salary
- Spouse Life - 1 time or 50% of employee coverage benefit amount (the lesser of the two)
- Child(ren) Life - \$5,000 per child

## Included in Life benefit coverage

- Accelerated Benefit
- Specified Disease Benefit (Basic Life Only)
- Travel Assistance & Life Services Tool Kit
- Repatriation Benefit for the Employee
- Funeral Assignment
- Options to continue coverage upon retirement or employment separation

## Long Term Disability (LTD) – (Insures your salary during a disability and unable to work)

- Employer chooses benefit waiting period (30-Day; 60-Day; 90-Day)
- 66 2/3% of the first \$7,500 monthly covered earnings

# Eligibility Rules for Employee

## Basic Life Enrollment

- Work 15 hours or more per week (confirm requirements with employer)
- Automatically enrolled by your employer

## Other Lines of Coverage

- Medical, dental, vision, additional life or long-term disability
- Work 20 hours or more per week (confirm requirements with employer)

## Employee is eligible for benefits if:

- Employer has determined the employee is eligible for benefits
- Employee is at work on the day coverage is scheduled to start
- Employee works the minimum qualifying number of hours established by the employer

# Eligibility Rules for Dependents

## Eligible Dependents

- Spouse
- Children - natural, adopted, or legal guardianship
  - Up to age 26 (married or unmarried)

## Proof of Dependency Required

Submit required proof with your application to avoid a delay of coverage for your dependents

- Social Security Number or Individual Tax Identification Number
- Marriage Certificate
- Birth Certificate
- Proof of other coverage if you are excluding a dependent from a line of coverage when you are enrolling at least one other eligible family member

# Effective Date of Coverage

## Basic Life

- 1<sup>st</sup> of the month following date of hire (first day actively at work)

## All other lines of coverage

- 1<sup>st</sup> of the month following employee date of hire coinciding with premium payroll deduction arrangements
  - Your employer determines your effective date

## Advise Employer

- If you are transferring benefits from another NMPSIA participating employer, to coordinate enrollment effective dates and premium collection
- If you are a return-to-work RETIREE covered under the New Mexico Retiree Health Care Authority (NMRHCA), the NMRHCA requires you to cancel retiree medical coverage and enroll for health coverage with your active employer



# Employer Contribution Rules

## Basic Life

- 100% paid by employer based on benefit level offered at the employer

## Additional and Dependent Life

- 100% paid by employee premium determined by age and base annual salary

## All other lines of coverage

- Employer contributes the majority percentage toward premium
  - The premium percentage is determined on your base annual salary
- Payroll deductions determined by your employer

# Timely Enrollment Requirement

- Enroll in other lines of coverage within 31 calendar days from date of hire (first day actively at work)
- If coverage is declined as a New Hire:
  - Decline medical, dental or vision - Open Enrollment in the fall with an effective date of January 1 of the following year, or with qualifying event
  - If Additional Life and/or Long-Term Disability is declined and/or you choose to enroll after the 31 day enrollment deadline
    - *Evidence of Insurability and approval by the carrier is required for Additional Life, Spouse Life and Long-Term Disability*
- Switching medical or dental plans or options is allowed annually during the fall with an effective date of January 1 of the following year

# Qualifying Event to Enroll

**Report life events within 31 calendar days from date of event**

- Birth of a child
- Adoption/Placement or Legal Guardianship
- Marriage
- Divorce
- Involuntary Loss of Other Coverage
- Promotion to a new job classification with salary increase
- Part-time to full-time employment change with salary increase

# General Information and Rules

## 2-Year Vision Rule

Vision coverage has a two-year enrollment requirement; the vision plan cannot be dropped until the employee and each enrolled dependent have been enrolled for two years

## Double Coverage Rule

NMPSIA rules do not permit double coverage within the NMPSIA group plans. If an employee, spouse, or their child work for a NMPSIA participating employer, neither can cover each other for the same lines of coverage

# General Information

## Insurance Fraud

Under NMPSIA Rules and Regulations, anyone who knowingly makes any false or fraudulent statement or representation shall forfeit all employee and dependent rights to coverage or benefits. In the event of prohibited actions by an official or employee of a participating school or other educational entity, the employer shall take the appropriate disciplinary action against the offending official or employee.

If such appropriate disciplinary action is not taken, NMPSIA reserves the right to terminate coverage for the participating school, charter or other education entity. *(Federal and State Insurance Laws Will Apply)*

# Closing Gaps in Care

## Access Affordable Care

### Get the Right Care at the Right Time

#### Awareness

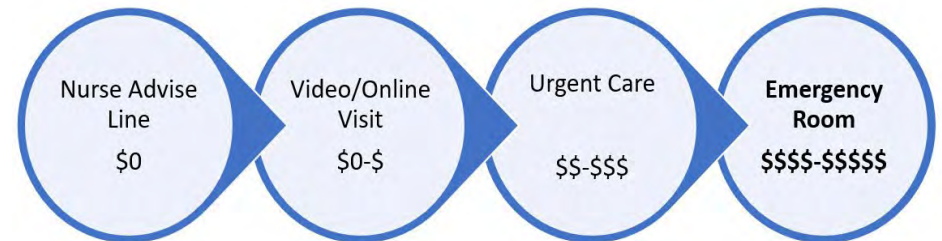
- Know your plan's benefits – <https://nmpsia.com>
- Program Guide
- Side-by-Side Medical Plan Comparison Chart
- Wellness programs offered - \$0 cost to members

#### Engagement

- Know your free in and out of network services
- Schedule routine primary care provider visits
- Register in each of your plan's member portals and/or cell phone apps
- Encourage your employer to create a staff wellness strategy with NMPSIA support

#### Risk Reduction

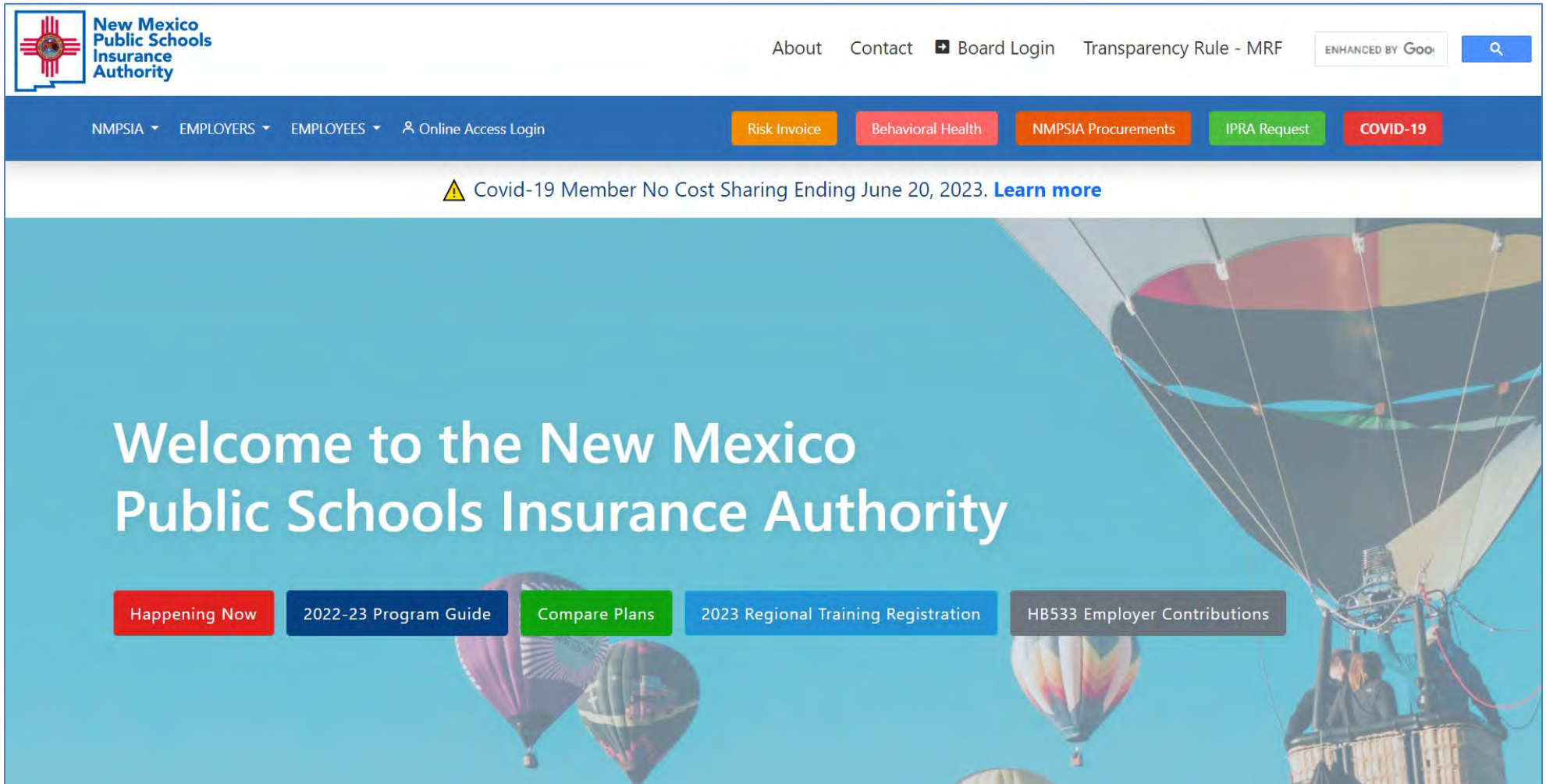
- Know your numbers
- Maintain preventive screenings
- Medicine Adherence
- Read your Explanation of Benefits (EOB)
- Confirm surgical procedures meet "medically necessary" requirements



#### Health Management

Right care and the right time

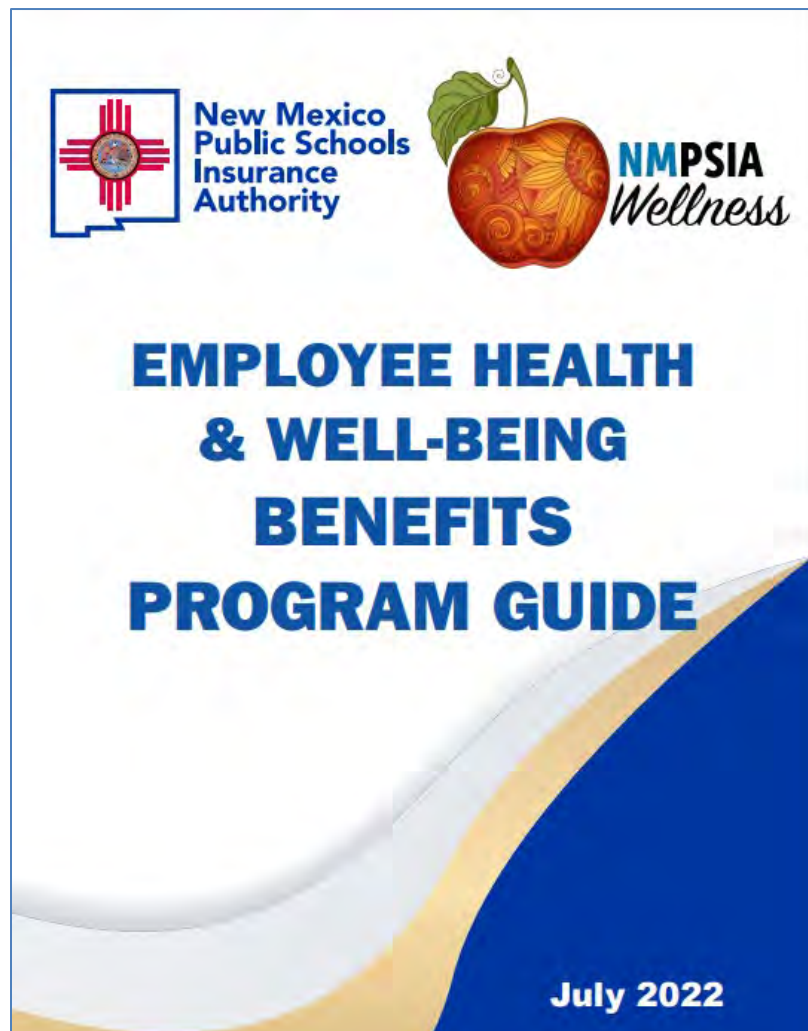
# Resources



The screenshot shows the homepage of the New Mexico Public Schools Insurance Authority. The header includes the organization's logo and name on the left, and navigation links for 'About', 'Contact', 'Board Login', and 'Transparency Rule - MRF' on the right. A search bar is also present. Below the header is a blue navigation bar with dropdown menus for 'NMPSIA', 'EMPLOYERS', and 'EMPLOYEES', along with an 'Online Access Login' link. A row of colored buttons provides quick access to 'Risk Invoice', 'Behavioral Health', 'NMPSIA Procurements', 'IPRA Request', and 'COVID-19'. A white banner below the navigation bar features a yellow warning triangle icon and the text: 'Covid-19 Member No Cost Sharing Ending June 20, 2023. [Learn more](#)'. The main content area has a blue background with a hot air balloon image. The central text reads 'Welcome to the New Mexico Public Schools Insurance Authority'. At the bottom of this area are five buttons: 'Happening Now' (red), '2022-23 Program Guide' (dark blue), 'Compare Plans' (green), '2023 Regional Training Registration' (blue), and 'HB533 Employer Contributions' (grey).

Website: <https://nmpsia.com/>

# Resources



Website: <https://nmpsia.com/>



# Resources

## Confirm and View Benefits Enrollment

Visit <https://nmpsiaonline.nmpsia.com/> Employee Login



New Mexico  
Public Schools Insurance Authority

Sign In...

Employee Login  
You are an Employee.

Employer Login  
You are an Employer.

Manager Login  
You are a Manager.



# NMPSIA

410 Old Taos Highway  
Santa Fe, New Mexico 87501  
Phone: 505.988.2736 or 1.800.548.3724  
Fax: 505.983.8670  
Website: <https://nmpsia.com/>

## Questions

Organization	Name	Title	Email
NMPSIA	Patrick Sandoval	Executive Director	<a href="mailto:Patrick.Sandoval@psia.nm.gov">Patrick.Sandoval@psia.nm.gov</a>
NMPSIA	Martha Quintana	Deputy Director	<a href="mailto:Martha.Quintana@psia.nm.gov">Martha.Quintana@psia.nm.gov</a>
NMPSIA	Cyndi Archuleta	Benefits and Wellness Manager	<a href="mailto:Cyndi.Archuleta@psia.nm.gov">Cyndi.Archuleta@psia.nm.gov</a>
NMPSIA	Kaylei Jones	Benefits and Wellness Program Coordinator	<a href="mailto:Kaylei.Jones@psia.nm.gov">Kaylei.Jones@psia.nm.gov</a>
NMPSIA	Leslie Martinez	Benefits Analyst	<a href="mailto:Leslie.Martinez@psia.nm.gov">Leslie.Martinez@psia.nm.gov</a>
NMPSIA	Kathy Payanes	Account Manager	<a href="mailto:K.Payanes@easitpa.com">K.Payanes@easitpa.com</a>

# Required Online Enrollment

## Effective January 1, 2024

**Kathy Payanes, Erisa**

# Employer

- New Hire (Basic Life Enrollment)
- Cancel EE
- Report LOA (Return and Change Date)

# We get it. Change is daunting. But you'll thank us for this one.

Reasons why...

- Efficiency (saves time)
- Reduces chance for errors
- Simplifies the process

# Overview of the Online System

## Employer Login and Access

NMPSIA Online Benefit System website address: <https://nmpsiaonline.nmpsia.com>



The screenshot displays the NMPSIA Online Benefit System website. The top navigation bar features the New Mexico Public Schools Insurance Authority logo and name. Below this, three login options are presented: Employee Login (You are an Employee), Employer Login (You are an Employer), and Manager Login (You are a Manager). The Employer Login button is circled in red. Below the login options, the Employer Sign in... form is shown, also circled in red. The form includes fields for District ID (10), Representative Name (BILLING1), and Password (\*\*\*\*\*). A Forgot Your Password link and Log In/ Home buttons are also visible.

New Mexico  
Public Schools Insurance Authority

Sign In...

Employee Login  
You are an Employee.

Employer Login  
You are an Employer.

Manager Login  
You are a Manager.

New Mexico  
Public Schools Insurance Authority

**Employer Sign in...**  
Please log in with your district id and password  
District ID:   
Representative Name:  BILLING1 ▾  
Password:   
[Forgot Your Password](#)  
[Log In](#) [Home](#)

# Home screen

Home	Inquiry	Review	New Hire	Employer Information	Cancel EE	Report LOA	Feedback	Logout
------	---------	--------	----------	----------------------	-----------	------------	----------	--------

Employer **SPRINGER MUNICIPAL SCHOOLS** Benefits10 Kathy Payanes

**SPRINGER MUNICIPAL SCHOOLS Policy (dist id: 10)**

<b>Medical</b>	Yes
<b>Dental</b>	Yes
<b>Vision</b>	Yes
<b>Basic Life Insurance</b>	Yes
<b>Additional(Voluntary) Life Insurance</b>	Yes
<b>Spouse Life Insurance</b>	Yes
<b>Dependent Life Insurance</b>	Yes
<b>Long Term Disability</b>	Yes
<b>Domestic Partner</b>	Yes
<b>Part Time Resolution</b>	No
<b>125K Plan</b>	No
<b>Open/Switch Enrollment Date</b>	01/01/2024

**Do not** use your browser's Back or Forward buttons to navigate the Online Benefit System. Use the **Previous** and **Next** options that appear on the bottom left and right of the screen.

Date (Click to change date)	Notice Type	Number of Notices Available
12/13/2022	Confirmation Notices	2
	COBRA Initial Notices	0
	COBRA Qualifying Event Notices	0
	COBRA Late Qualifying Event Notices	0

Home	Inquiry	Review	New Hire	Employer Information	Cancel EE	Report LOA	Feedback	Logout
------	---------	--------	----------	----------------------	-----------	------------	----------	--------

Employer SPRINGER MUNICIPAL SCHOOLS Benefits10 Kathy Payanes ER\_SingleNewHire

## Employer New Hire

SSN:  Effective Date:

Social Security No.	Last Name	First Name	Middle Name	Suffix
987-65-4321	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date Of Birth	Marital Status	Gender	Home Phone	Work Phone	Cell Phone	E-Mail	Preferred Contact
<input type="text"/>	Single ▾	▾	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Physical Address ▾

Mailing address(Box#or Street Address)	Zip	City	State	County
line 1 <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
line 2 <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Employer (District or Entity Name): SPRINGER MUNICIPAL SCHOOLS

Job Title	Date of Hire	Base Annual Salary	No.of Hours Contracted Per Week	Basic Life Effective Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	08/01/2023

(Variable hour employees are only eligible to enroll in **medical** benefits at this time.)

Checking the variable hour employee check box will change "Date of Hire" to "Date Eligible for Benefits" (the date the employer offered medical coverage to the variable hour employee) and allow zero values for annual salary and number of hours worked per week to be entered.

## Demonstration on how to enroll a New Hire in Basic Life



# Erisa will receive notification of the transaction via the District Transactions Check on NMPSIA/Erisa system

District Transactions Check

Dist ID: ALL ▾ Staff ID: ALL ▾

Dist	Dist Name	SSN	EE Name	Tran Type	Start	Date Of Hire	BLF Effective Date	Date Of Termination	Benefit Expiration Date	Inquiry
<input type="checkbox"/>	10 Springer Municipal Schools	999-010-001	Tick, Luna	Single New Hire	KP	06/01/2023	07/01/2023	12/31/2999		

A New Hire employee receives this Enrollment Notification containing information needed to login and access their enrollment account online



**New Mexico Public Schools Insurance Authority  
(NMPSIA)**



c/o Erisa Administrative Services, Inc. (505) 988-4974 or (800) 233-3164  
P. O. Box 9054; Santa Fe, NM 87504-9054

**Enrollment Notification**

05/22/2023

**SPRINGER MUNICIPAL SCHOOLS**

Dist ID: 010

Luna Tick

HIPAA ID: 2468ABC

123 This Street

That City NM 99999

Dear NMPSIA Insurance Coverage Enrollee,

This notice contains information needed to login and access your enrollment account online. Your employer's District ID and your HIPAA ID appear above. Please keep this document in a safe place.

Website: <https://nmpsia.com>

Navigation: Members > NMPSIA Online Benefit System

You have been enrolled in your employer paid Basic Life Insurance plan. Please check your enrollment status on this site.

We invite you to visit <https://nmpsia.com> for general information about the NMPSIA plans and benefits available to you. We hope that you use this tool as another avenue to view your NMPSIA insurance enrollment information.

Thank you,  
Juliet Baca  
Erisa Administrative Services, Inc.

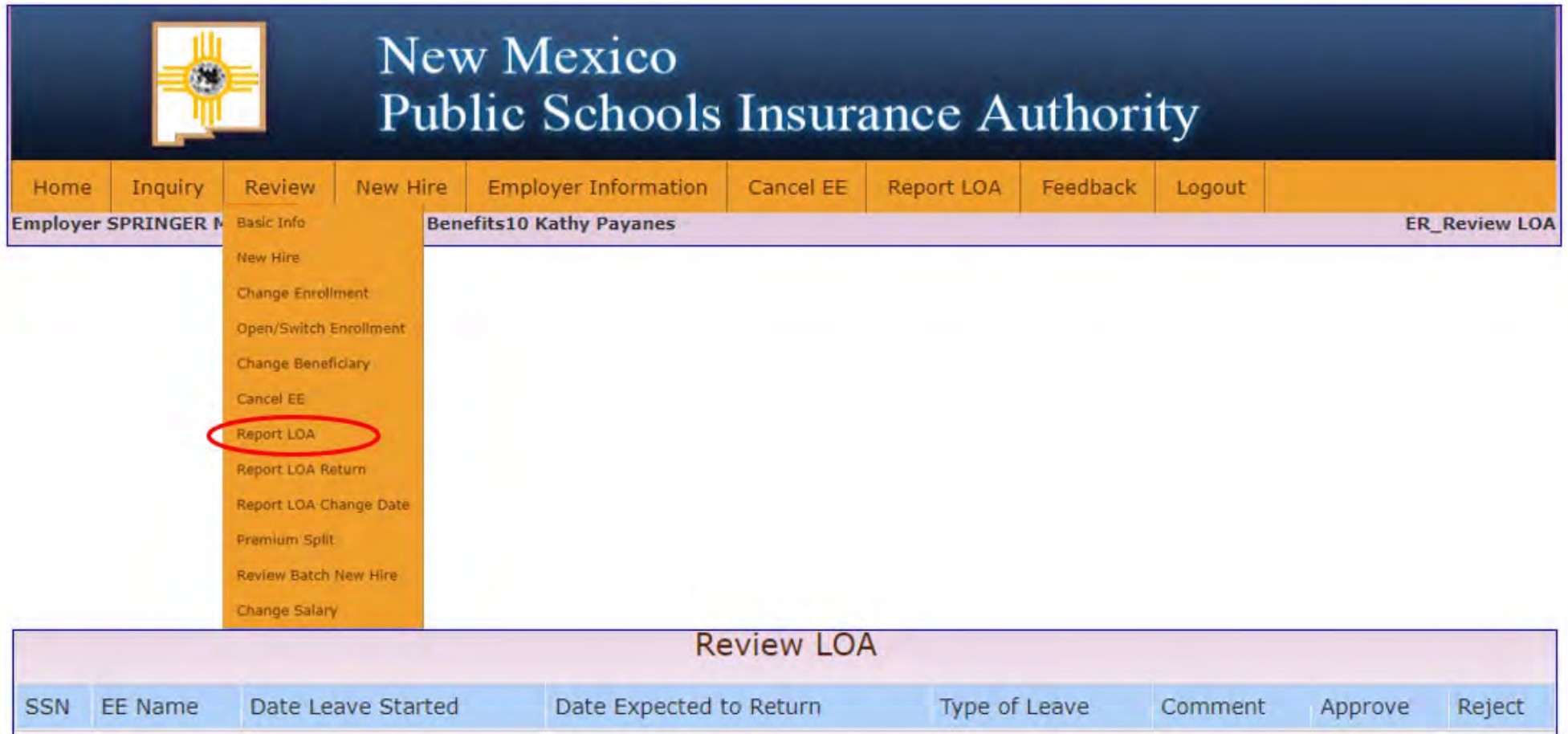
# Cancel Employee

Home	Inquiry	Review	New Hire	Employer Information	Cancel EE	Report LOA	Feedback	Logout	
Employer SPRINGER MUNICIPAL SCHOOLS Benefits10 Kathy Payanes									ER_CancelEE
HIPAA ID	SSN	EE Name	Last Date of Coverage	Received Date	Note Type				
									▼
									▼
									▼
									▼
									AddRow
Submit			Reset			Print			

Please note if cancellation of coverage is related to the death of an employee, you should contact your Erisa Benefits Representative Juliet Baca at (800) 233-3164 or [jbaca@easitpa.com](mailto:jbaca@easitpa.com).

## Demonstration on how to CANCEL an Employee

# Report LOA



The screenshot shows the web application interface for the New Mexico Public Schools Insurance Authority. At the top, there is a navigation bar with the following menu items: Home, Inquiry, Review, New Hire, Employer Information, Cancel EE, Report LOA, Feedback, and Logout. Below the navigation bar, the user is logged in as 'Employer SPRINGER M' and is viewing the 'Benefits10 Kathy Payanes' record. The 'Review' menu is expanded, showing a list of options: Basic Info, New Hire, Change Enrollment, Open/Switch Enrollment, Change Beneficiary, Cancel EE, Report LOA (highlighted with a red circle), Report LOA Return, Report LOA Change Date, Premium Split, Review Batch New Hire, and Change Salary. Below the menu, the 'Review LOA' section is visible, containing a table with the following columns: SSN, EE Name, Date Leave Started, Date Expected to Return, Type of Leave, Comment, Approve, and Reject.

Review LOA							
SSN	EE Name	Date Leave Started	Date Expected to Return	Type of Leave	Comment	Approve	Reject




New Mexico  
Public Schools Insurance Authority

Home Inquiry Review New Hire Employer Information Cancel EE Report LOA Feedback Logout

Employer SPRINGER M Benefits10 Kathy Payanes ER\_Review LOA

- Basic Info
- New Hire
- Change Enrollment
- Open/Switch Enrollment
- Change Beneficiary
- Cancel EE
- Report LOA
- Report LOA Return**
- Report LOA Change Date
- Premium Split
- Review Batch New Hire
- Change Salary

Review LOA Return					
SSN	EE Name	Return Date	Type	Approve	Reject



## New Mexico Public Schools Insurance Authority

Home
Inquiry
Review
New Hire
Employer Information
Cancel EE
Report LOA
Feedback
Logout

Employer SPRINGER M
ER\_Review LOA

- Basic Info
- New Hire
- Change Enrollment
- Open/Switch Enrollment
- Change Beneficiary
- Cancel EE
- Report LOA
- Report LOA Return
- Report LOA Change Date
- Premium Split
- Review Batch New Hire
- Change Salary

Benefits10 Kathy Payanes

### Review LOA

SSN	EE Name	Date Leave Started	Date Expected to Return	Type of Leave	Comment	Approve	Reject
-----	---------	--------------------	-------------------------	---------------	---------	---------	--------

Again, whether a New Hire or Cancel EE, Erisa will receive notification of the transaction via the District Transactions Check on IBAC.

District Transactions Check

Dist ID: ALL

Dist	Dist Name	ESM	EE Name	Tran Type	Staff	Date Of Hired	ELF Effective Date	Date Of Termination	Benefit Expiration Date	Inquiry
<input type="checkbox"/>	10	Springer Municipal Schools	999-010-001	Tick, Luna	Cancel EE	KP		07/31/2023		


# Employee

- Change Beneficiary
- Open/Switch (Change Enrollment)
- Change Basic Info




# Employee Login and Access

Using the information on the Enrollment Notification sent to them at the time of enrollment an employee can make certain changes



**New Mexico Public Schools Insurance Authority  
(NMPSIA)**



c/o Erisa Administrative Services, Inc. (505) 988-4974 or (800) 233-3164  
P. O. Box 9054; Santa Fe, NM 87504-9054

**Enrollment Notification**

05/22/2023

**SPRINGER MUNICIPAL SCHOOLS**

Luna Tick  
123 This Street  
That City NM 99999

Dist ID: 010  
HIPAA ID: 2468ABC

Dear NMPSIA Insurance Coverage Enrollee,

This notice contains information needed to login and access your enrollment account online. Your employer's District ID and your HIPAA ID appear above. Please keep this document in a safe place.

Website: <https://nmpsia.com>

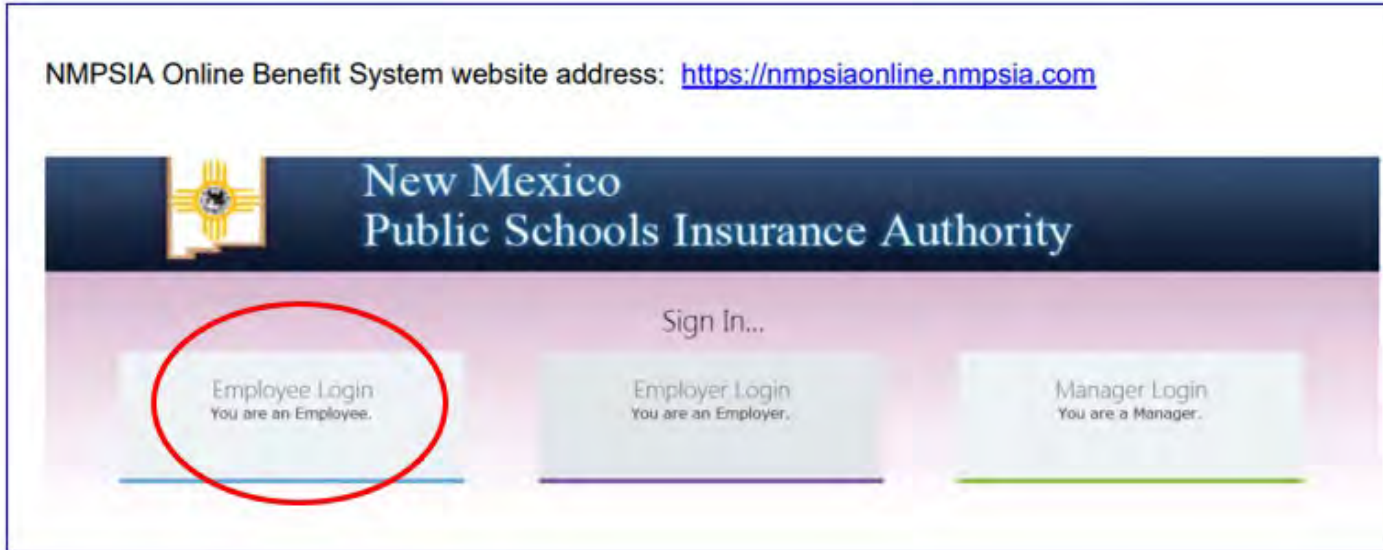
Navigation: Members > NMPSIA Online Benefit System

You have been enrolled in your employer paid Basic Life Insurance plan. Please check your enrollment status on this site.

We invite you to visit <https://nmpsia.com> for general information about the NMPSIA plans and benefits available to you. We hope that you use this tool as another avenue to view your NMPSIA insurance enrollment information.

Thank you,  
Juliet Baca  
Erisa Administrative Services, Inc.

NMPSIA Online Benefit System website address: <https://nmpsiaonline.nmpsia.com>



**Employee Sign in...**

Sign in with your HIPAA ID:  Sign in with your user defined login option:  Sign in with your SSN number:

Please log in with your SSN and Birthday:

Employer Name:

SSN (Please do not use dashes or spaces):

Date of Birth(MMDDYYYY):

Sign in with  
HIPAA ID or  
SSN

Enter SSN here  
Enter DOB here

Select  
employer  
name  
from  
drop  
down list



**New Mexico Public Schools Insurance Authority  
(NMPSIA)**



c/o Erisa Administrative Services, Inc. (505) 988-4974 or (800) 233-3164  
P. O. Box 9054; Santa Fe, NM 87504-9054

**Enrollment Notification**

05/22/2023

**SPRINGER MUNICIPAL SCHOOLS**

Dist ID: 010

Luna Tick

HIPAA ID: 2468ABC

123 This Street

That City NM 99999

Dear NMPSIA Insurance Coverage Enrollee,

This notice contains information needed to login and access your enrollment account online. Your employer's District ID and your HIPAA ID appear above. Please keep this document in a safe place.

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Thank you,  
Juliet Baca  
Erisa Administrative Services, Inc.

# An Employee can view and perform transactions under these tabs

Main	<b>View or Change Basic Information</b>	<b>Enrollment and Plan Information</b>	Beneficiary	Contact Us	Management	Tutorial	Logout
	View Basic Information	View					
	Change Basic Information	NMPSIA Benefit Plan Information					
		New Hire					
		Change Enrollment					
		Change Beneficiary					
		Open/Switch Enrollment					
		Enrollment Notice					

# Questions?

# Break & Group Stretch

## 1:45 – 2:00

### Coming up:

**2:00 p.m.**      **POMS - Karen Harris Mestas**  
                    ○ Ergonomics Assessment

**2:45 p.m.**      **Closing Remarks**



# Ergonomics for All School Staff

Karen Mestas-Harris, OTR/L, CEAS II

# Objectives

- Poms Team
- Ergo Program Preview
- Workers' Comp and Musculoskeletal Disorder Claims
- Ergonomic Principles
- Setting up your Workstation





# Ergonomic Mindset-Work Athlete



## Sports Athlete

Teams practice 2-4 hours a day

Most sports teams have games 1-2 times a week

Basketball has an 8 month season

Athletes mentally and physically prepare for their sport



## Work Athlete

You work 8-12 hours a day

You work 5-6 days a week

You likely work 11-12 months a year

We want you to be the athlete that trains and practices self care to prevent injuries for work and home tasks

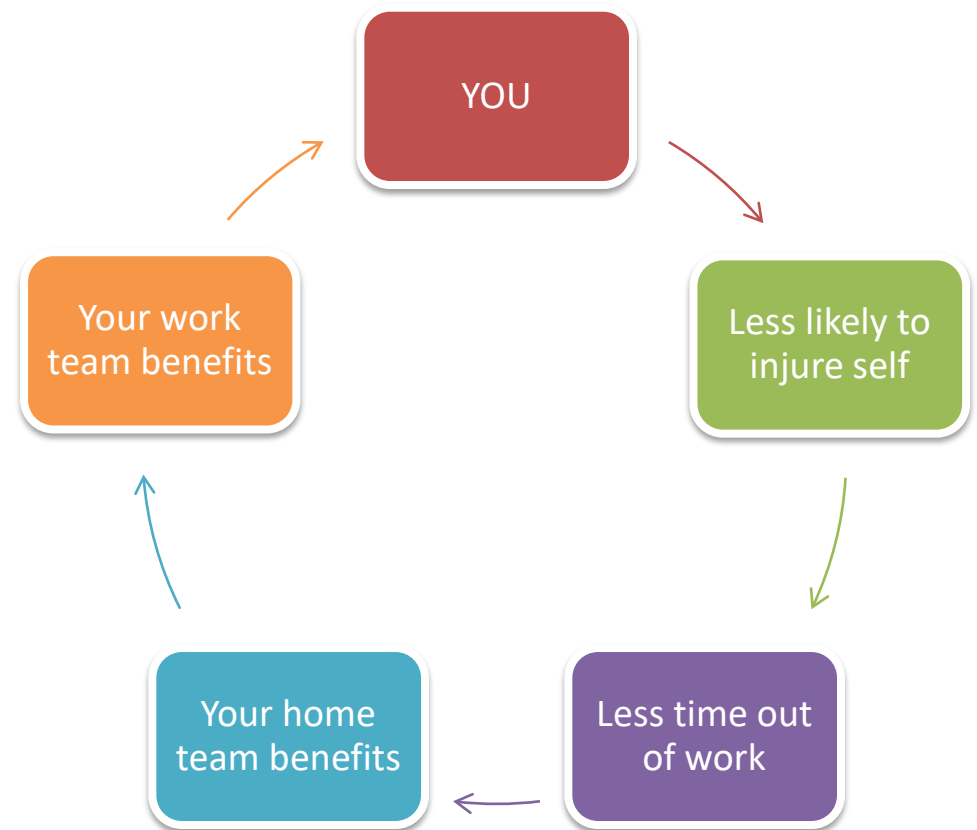
# Who is Poms and how can we help minimize risk?



- Karen Mestas-Harris, OTR/L, CEAS II
- Senior Manager, Risk Services/Ergonomics
- Occupational Therapist
- Teacher
- Ergonomic Specialist

# Who cares about Ergonomics?

- Who looks after you?
- Who do you look after?
- Who is your support system?
- What is the process to file an injury?
- Do you work injured?
- Injury Prevention
- Health and wellness responsibility
- Happy and healthy employees



# Injuries, Risk Factors, and Ergonomics

- Most injuries among school employees are:
  - Slips, trips, and falls
  - Strain (by lifting or by repetitive motion)
- Job risk factors by occupation
  - Teacher/EA
    - Sped vs Regular
  - Custodian
  - Cafeteria
  - Secretary
  - Bus Driver
  - Maintenance
  - Administration



Let's look back on  
7/1/2022-6/30/2023  
School Year

Workers Comp Claims (3066) Total  
Incurred \$49,949,196.59

---

*Musculoskeletal Disorder (MSD)*

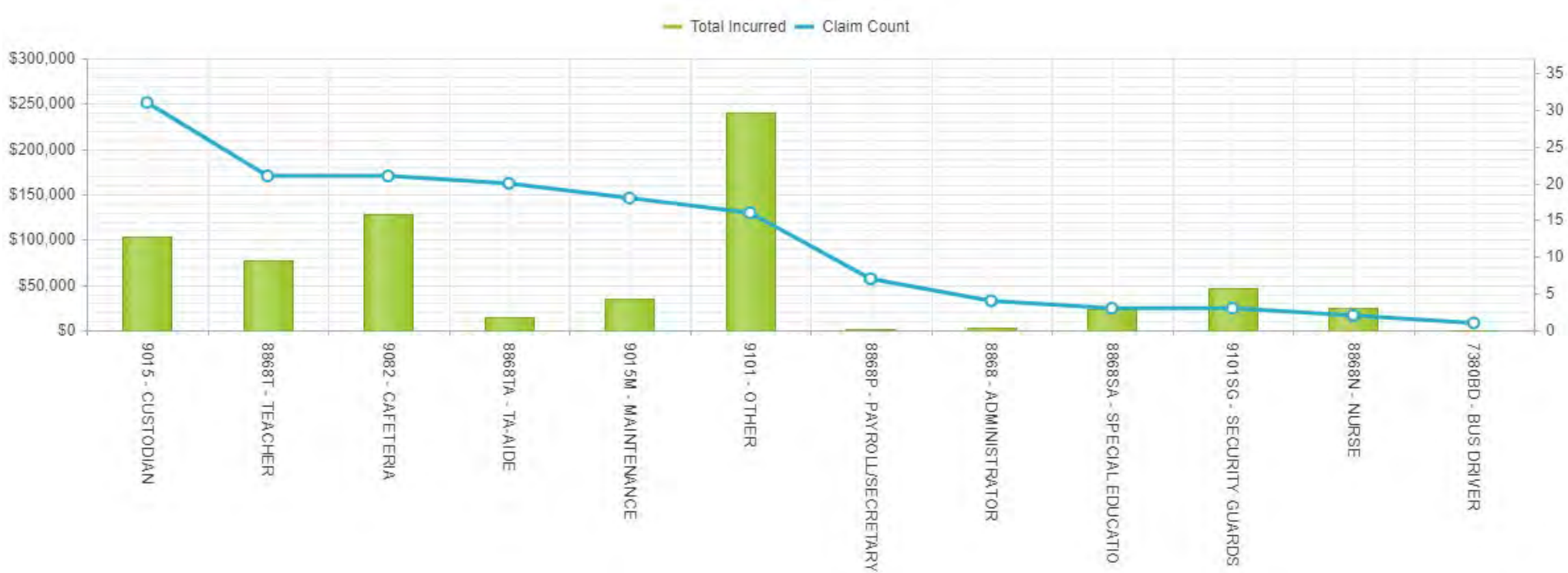
Total MSD Incurred \$696,951.85

Total MSD Claims 147

Average Cost per MSD Claim=\$4741.17



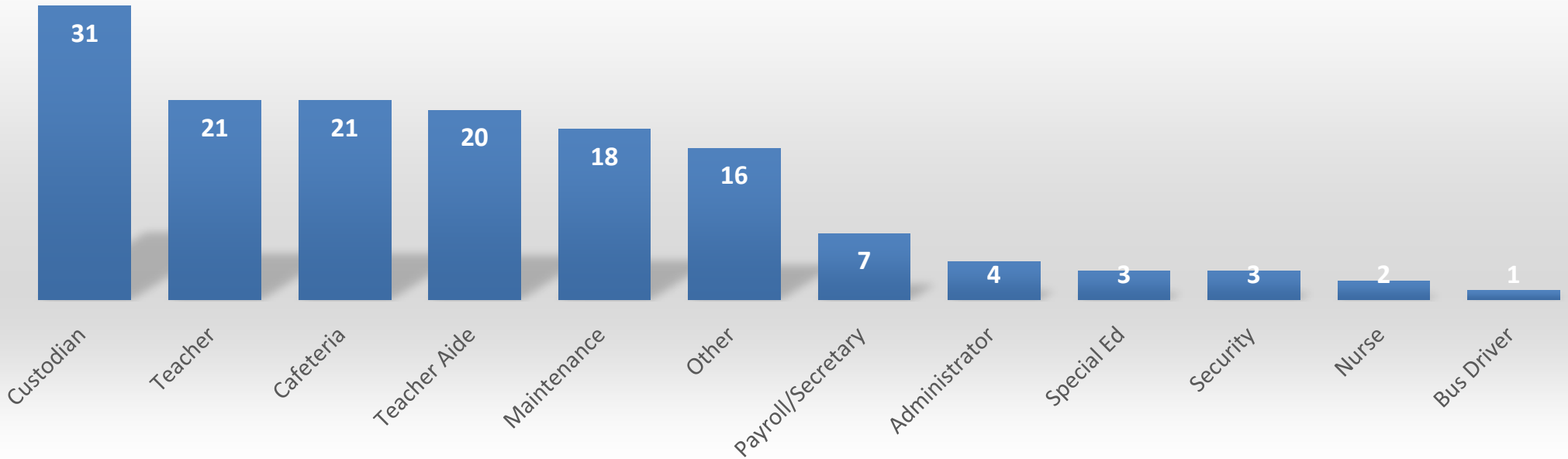
# 2022/2023 School Year MSD Trends



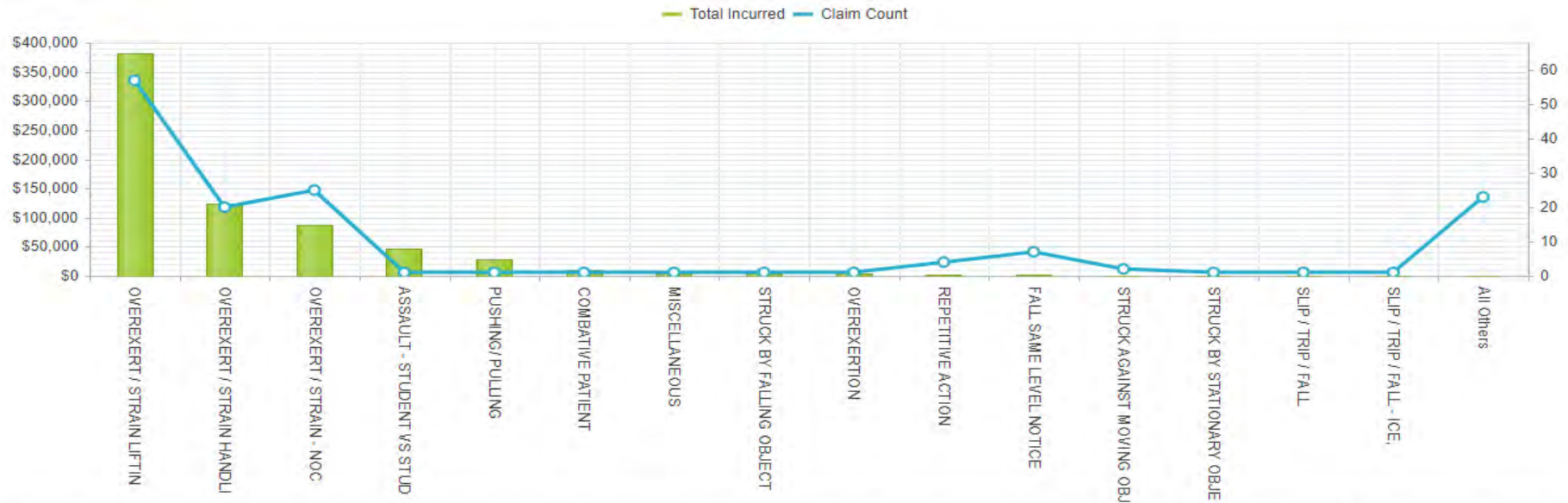
*Other (16 total): home liaison, substitute teacher (2), director, EA, clerical, social worker, superintendent, library tech, maintenance worker, EBHA (sped aide), groundskeeper, program specialist, instructional coach, mail courier, speech therapist*

# MSD Claims 2022-2023 SY by Occupation

Claim Count



# Claims 2022-2023 SY by Cause



	Cause (Analysis 1)	Paid	Out Reserve	Recovered	Total Incurred	Claim Count	Cost per Claim
	OVEREXERT / STRAIN LIFTING	\$159,134.81	\$223,455.59	\$0.00	\$382,590.40	57	\$6,712.11
	OVEREXERT / STRAIN HANDLING	\$95,295.85	\$29,340.88	\$0.00	\$124,636.73	20	\$6,231.84
	OVEREXERT / STRAIN - NOC	\$32,067.83	\$55,648.56	\$0.00	\$87,716.39	25	\$3,508.66
	ASSAULT - STUDENT VS STUDENT	\$29,481.52	\$16,263.38	\$0.00	\$45,744.90	1	\$45,744.90
	PUSHING/ PULLING	\$11,901.50	\$15,729.76	\$0.00	\$27,631.26	1	\$27,631.26
	COMBATIVE PATIENT	\$1,690.53	\$8,122.77	\$0.00	\$9,813.30	1	\$9,813.30
	MISCELLANEOUS	\$682.83	\$4,279.47	\$0.00	\$4,962.30	1	\$4,962.30
	STRUCK BY FALLING OBJECT	\$12.30	\$4,950.00	\$0.00	\$4,962.30	1	\$4,962.30
	OVEREXERTION	\$12.30	\$3,600.00	\$0.00	\$3,612.30	1	\$3,612.30
	REPETITIVE ACTION	\$773.30	\$1,103.96	\$0.00	\$1,877.26	4	\$469.32
	FALL SAME LEVEL NOTICE	\$1,138.78	\$0.00	\$0.00	\$1,138.78	7	\$162.68
	STRUCK AGAINST MOVING OBJECT	\$627.54	\$344.76	\$0.00	\$972.30	2	\$486.15



# How can we impact MSD claims and employee satisfaction?

- Districts
  - Employee Wellness
  - Training
  - Mentorship
- Poms Ergonomics Program
  - Newsletter/Handouts
  - Webinars/In-Person Training
  - Ergonomic Evaluations
  - Job Hazard Analysis
  - Claim Review with Trend Analysis



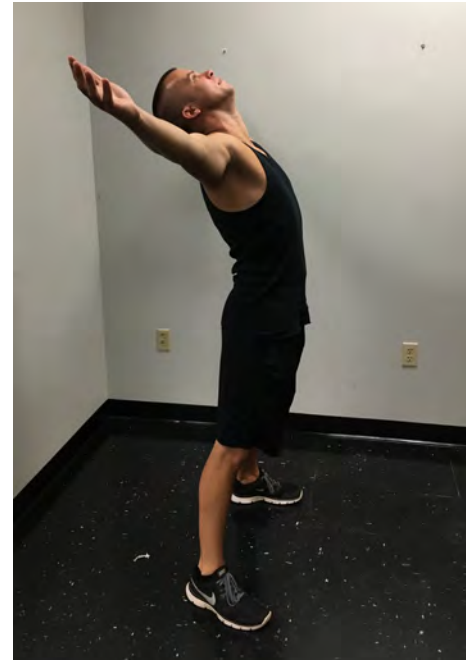
# What is Ergonomics?

- How you do your job and guide on how to complete tasks with more efficiency, safety and comfort.
- Same job requirements but we are all different.
- What personal difficulties or strengths are there to consider?



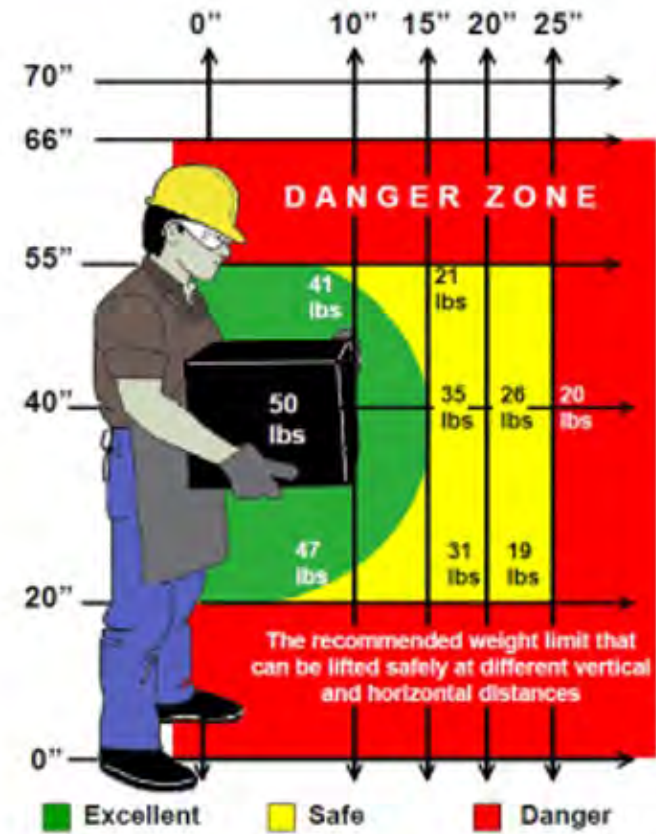
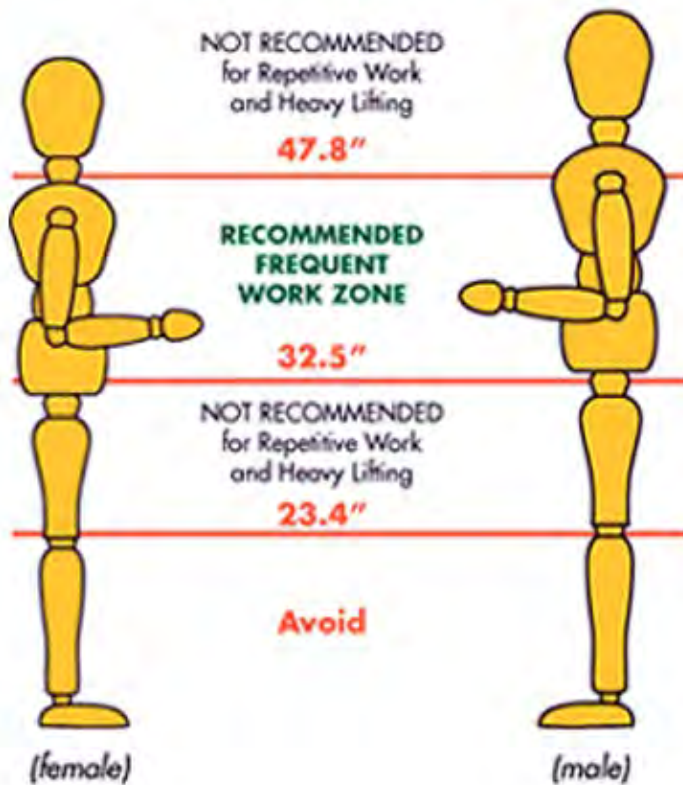
# Ergo Breaks

- Micro-breaks (do the opposite)
- Helps brain refocus
- Gives body time to recover
- Use timers or transitions
- Work athlete



# Powerzone

## Vertical Reaches



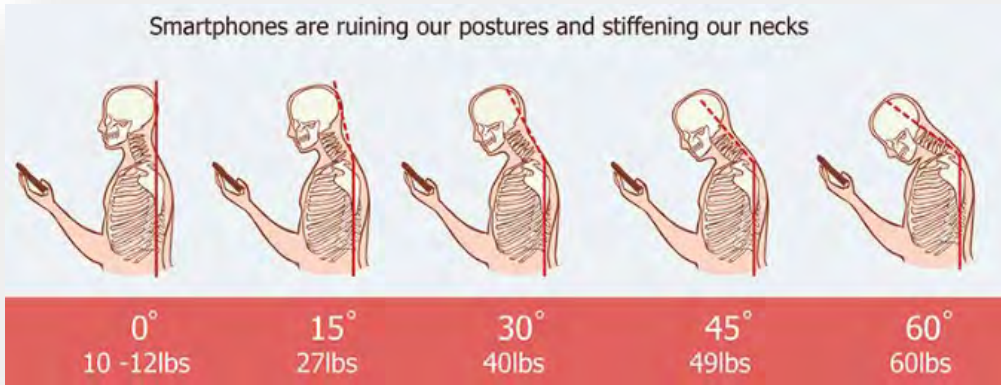
# Work Zones



# Tech Neck and Posture



# Tech Neck



# Work Zones and Body Postures

## Awkward Postures - Low work

Bending



Kneeling



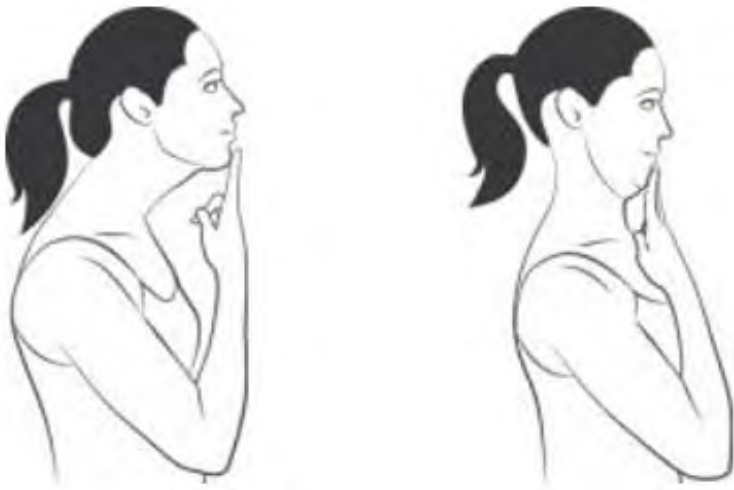
Squatting



These postures are hard on the back and the knees







# Ergonomic Principles

## Work in neutral positions/postures

- Healthy spine-S curve



## Decrease the need for excessive force

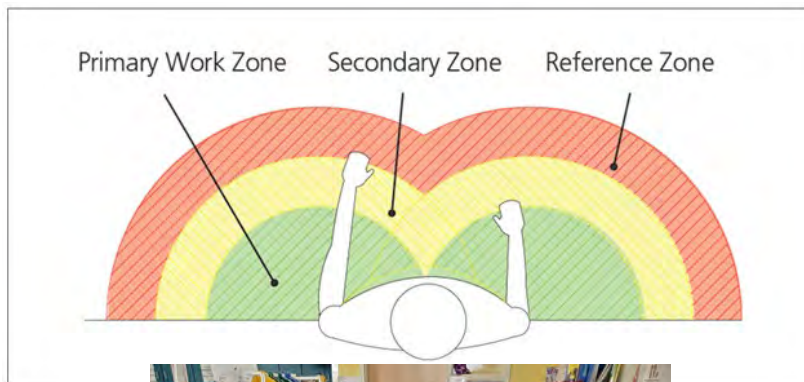
- Pushing, pulling, lifting heavy items can strain your joints
- Use tools or strategies to move items



# Ergonomic Principles

## Keep materials within easy reach

- T-rex power zone
- Modify your environment to keep most frequent items within reach



## Work at the proper height

- Too high or too low can strain back, neck, and shoulders



# Ergonomic principles at work



## Reduce unnecessary motions

- Repetition-look for ways to minimize or change sides



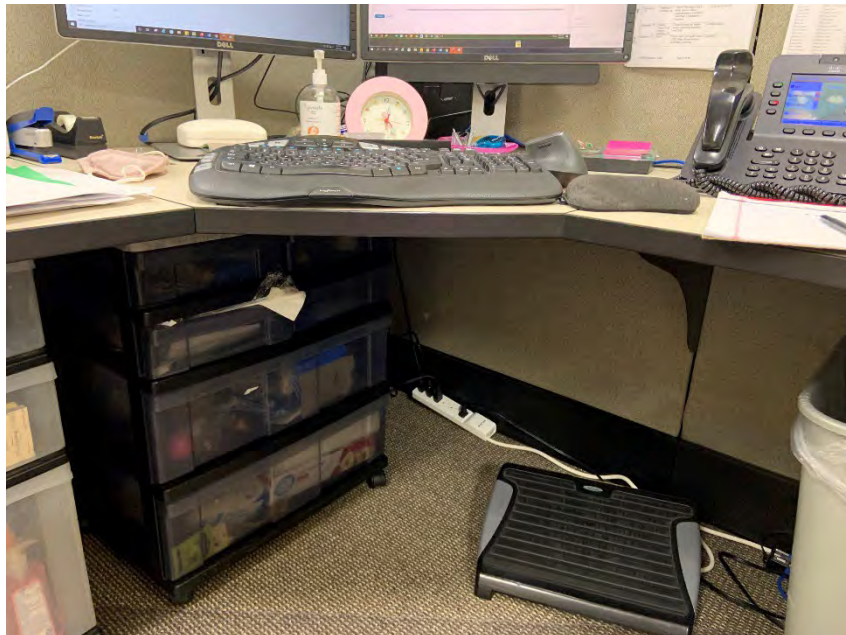
## Minimize static load

- Reduce unnecessary motions



## Minimize contact stress

- Tool or surface creates pressure points



## Leave adequate clearance

- Do you have enough room for head, knees, and feet?
- Do you have a clear view?



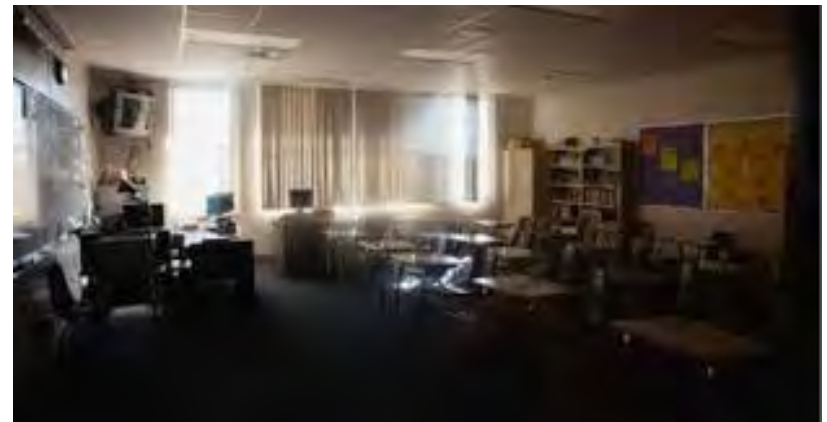
## Move and stretch throughout the day

- Stretch before lifting
- Footwear or inserts
- Motion is lotion



## Keep the environment comfortable

- Lighting/temperature
- Glare

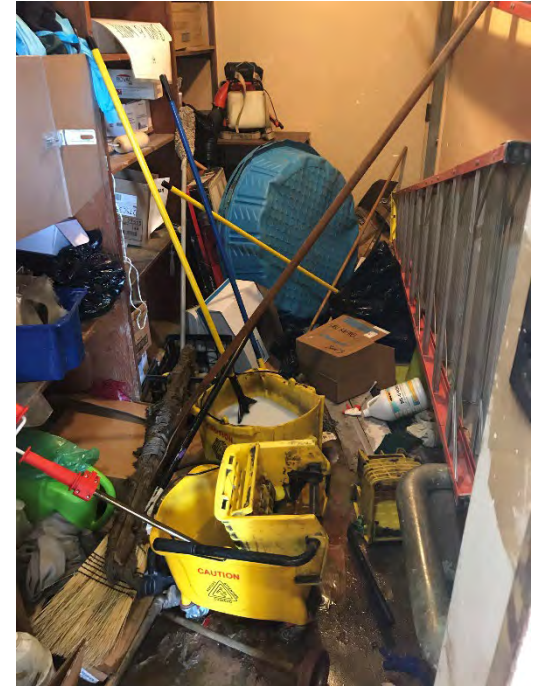


# Setting up your workstation

- Kitchen



- Custodian

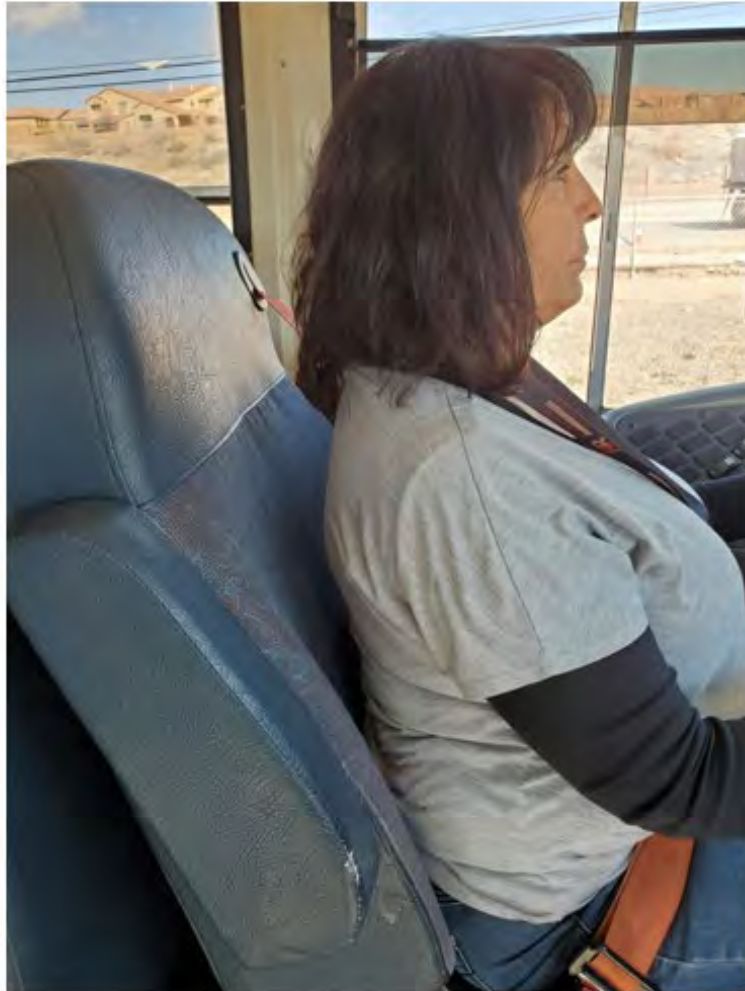




# Maintenance/Custodian



# Bus Driver



# The Basics for Workstation Setup



Chair

Desk

Monitor

Keyboard

Mouse

# She has “the 5” - but not an ergonomic setup



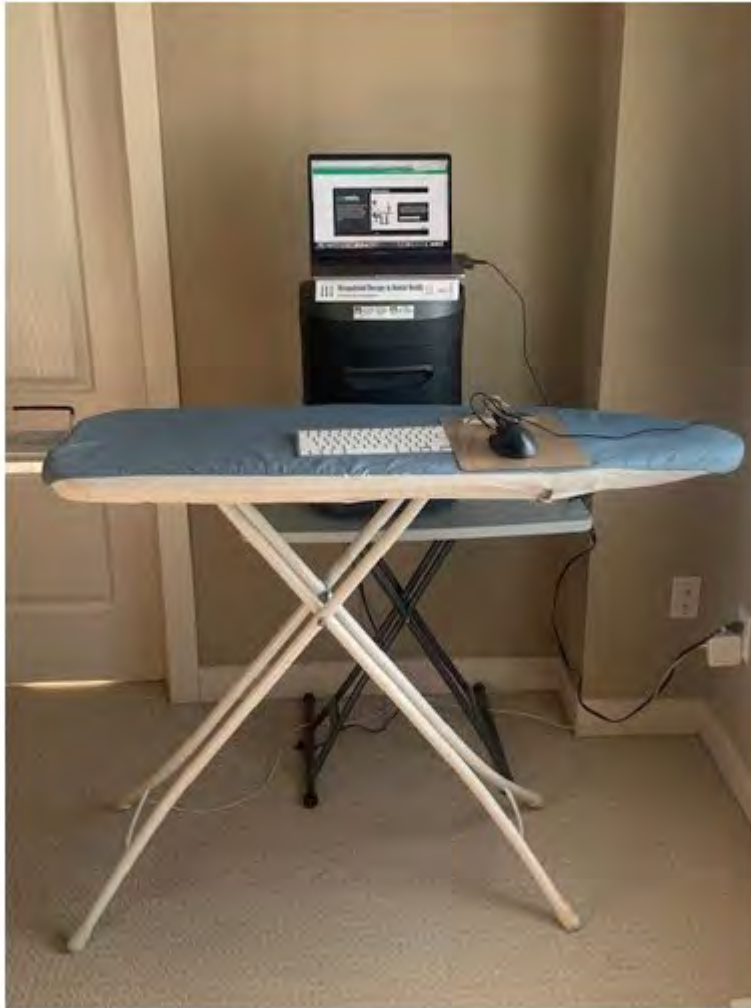
# Chair/Desk

**Don't Perch on the Edge of  
Your Chair.  
Use Your Back Support.**

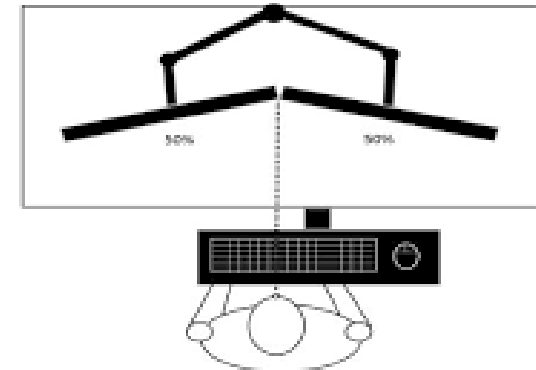
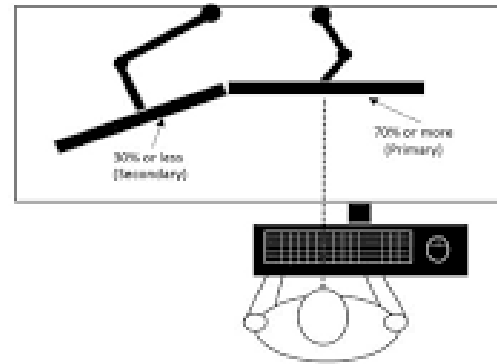
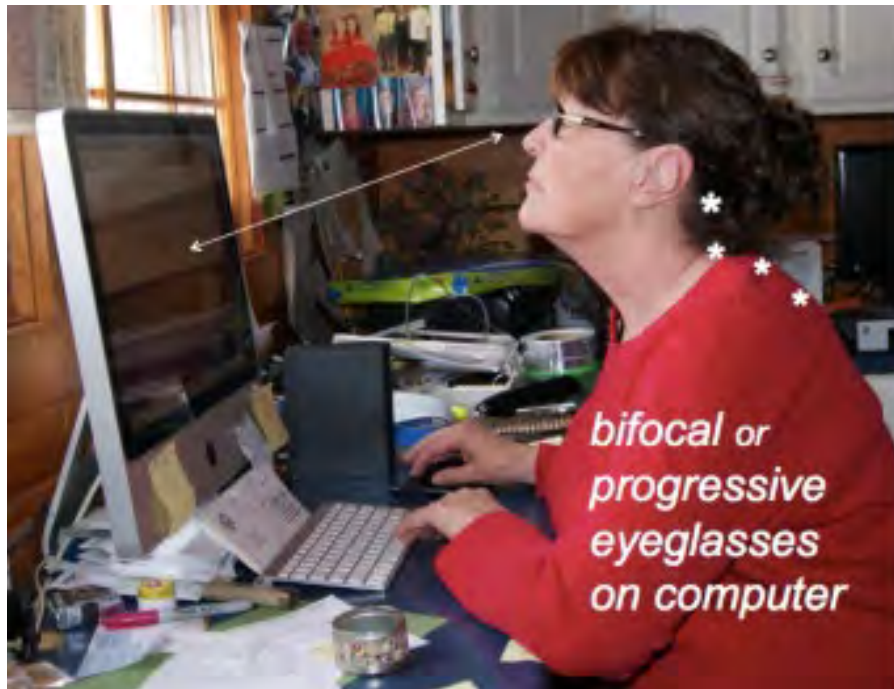
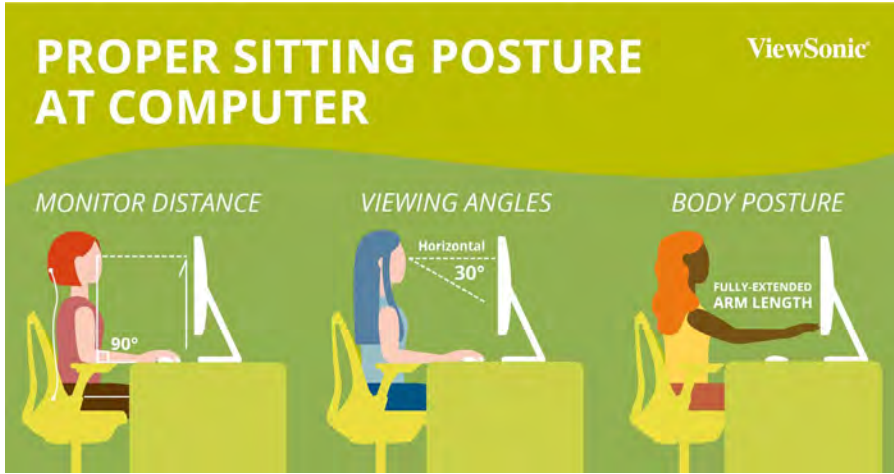




# Desk-Standing Options

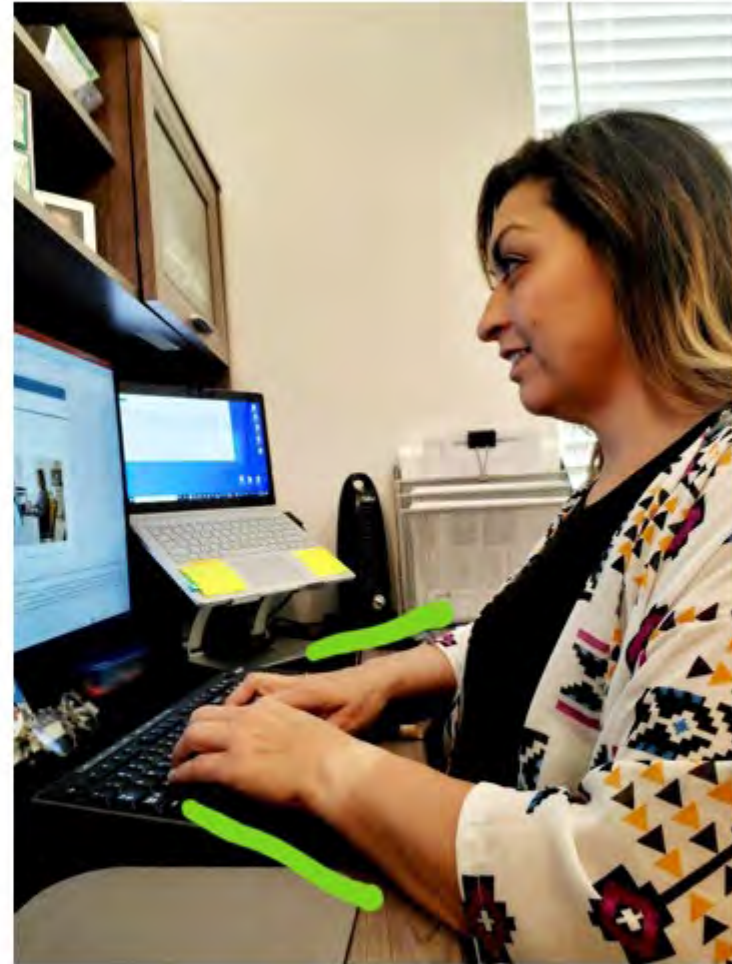
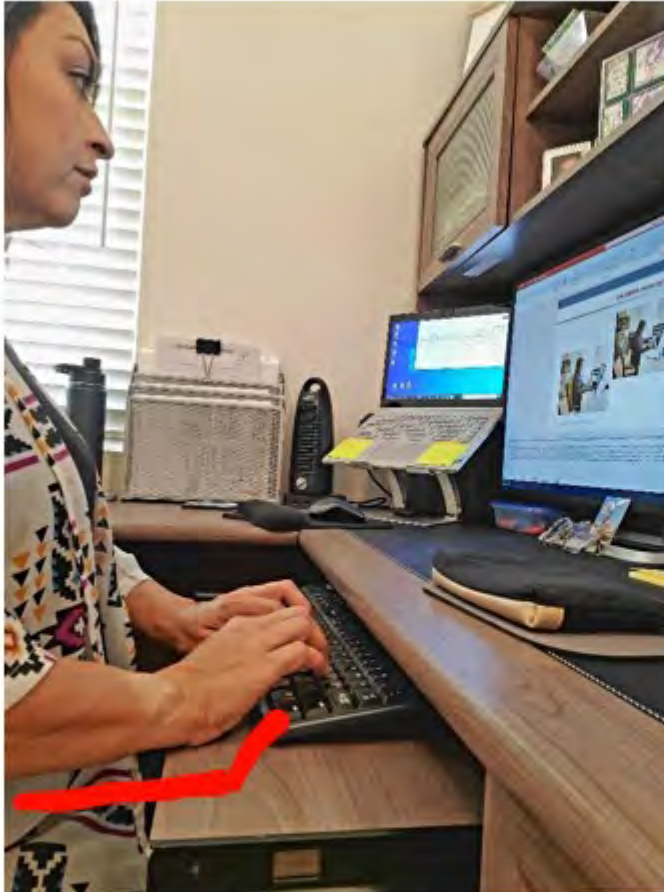


# Monitor





# Keyboard



**Keyboard in front of you.**

**B at Belly Button.**

**Shoulders relaxed and elbows close to body**

**Wrists in line with forearms**

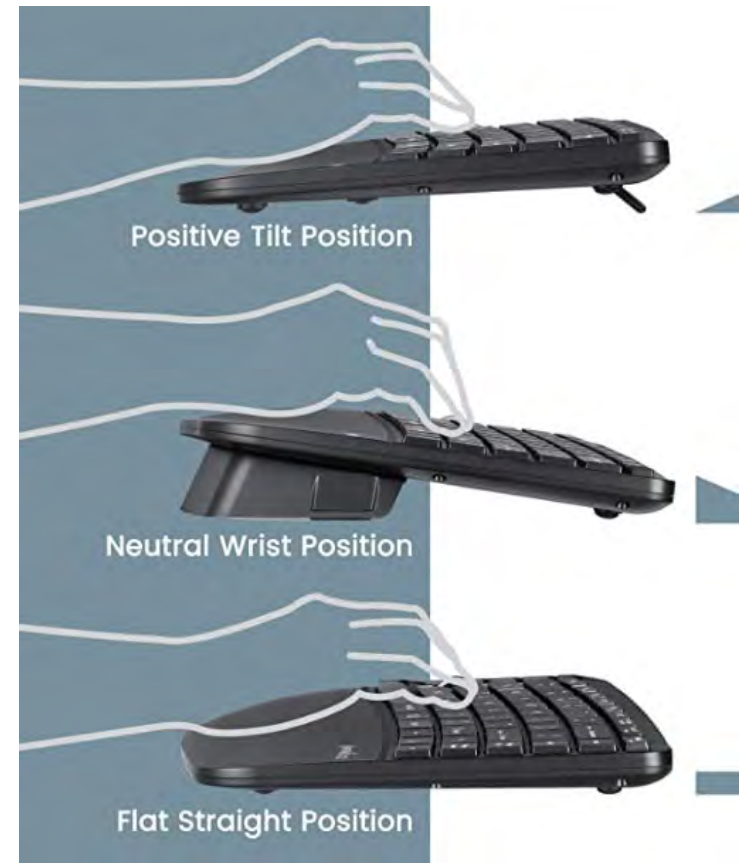
# Keyboard

Split Design  
for Natural Typing

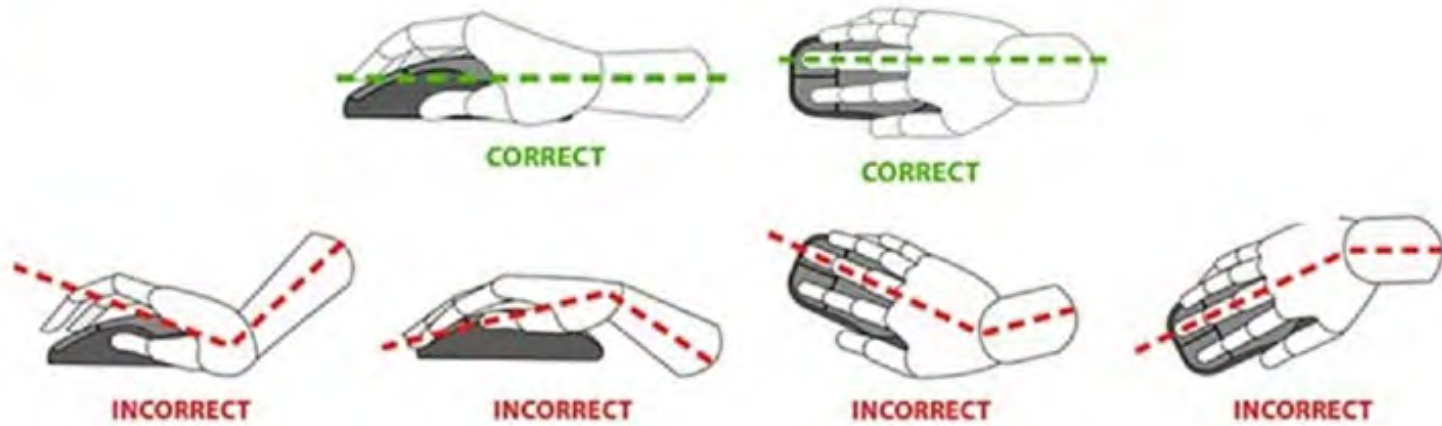


## The Narrow Keyboard

Allows the mouse to be much closer



# Mouse



## Neutral Posture

### Neutral Wrist Posture:

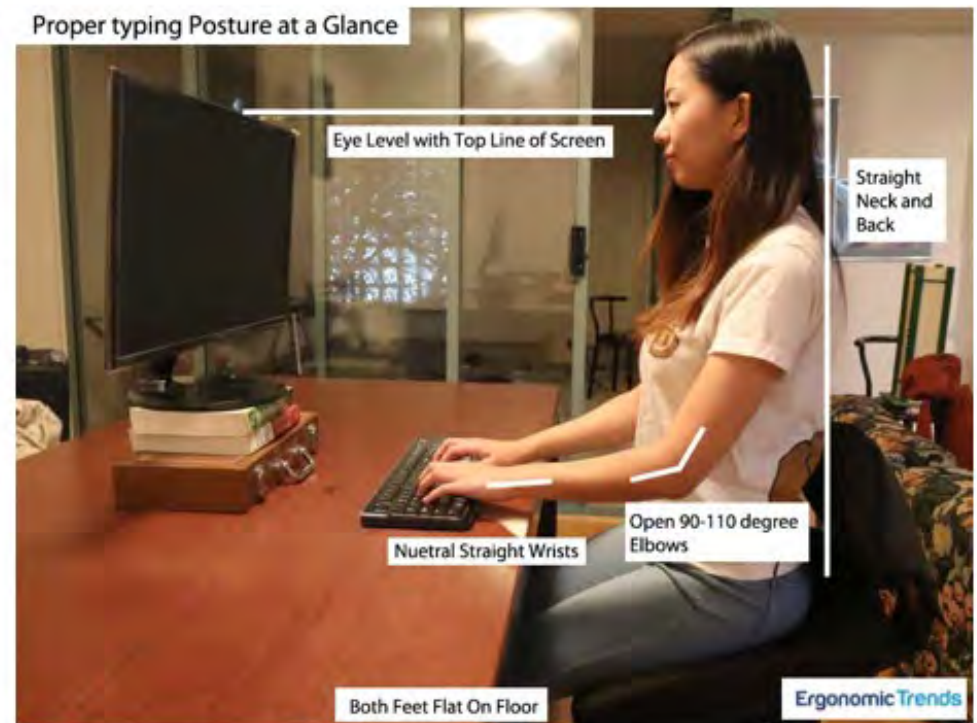
Deviations from this posture increase the risk of injury.



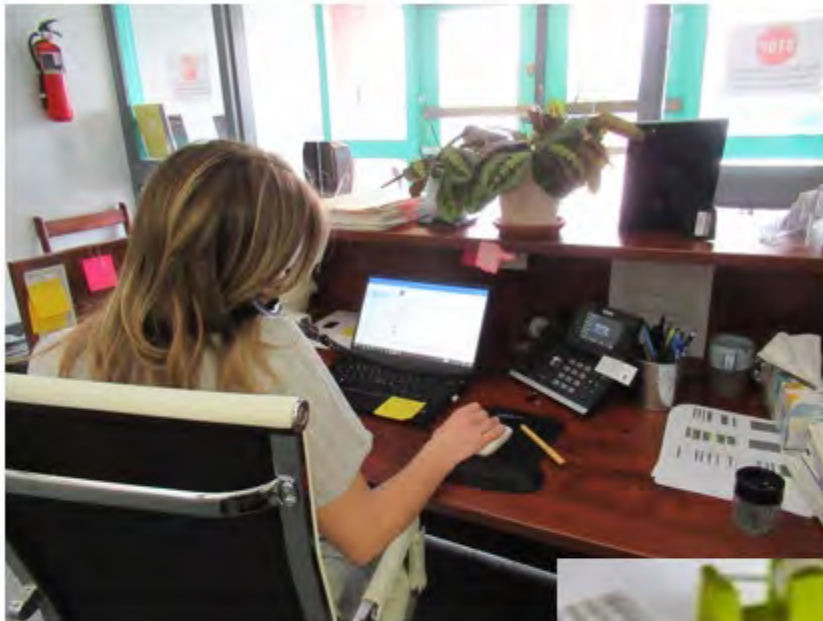
# More Power Zone



Proper typing Posture at a Glance



# Other Items To Consider



Headset

Wrist support

Document holder

Tablet Holder

Electric stapler

# 20/20/20 Rule



FOR EVERY

**20**

MINUTES  
ON THE COMPUTER

**STOP**

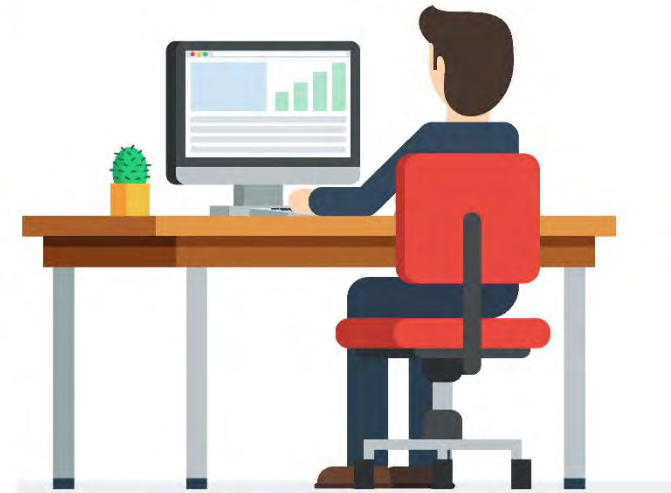
LOOK AT SOMETHING

**20**

FEET  
AWAY FOR

**20**

SECONDS



THIS GIVES YOUR EYES A BREAK, HELPS TO REDUCE EYE STRAIN,  
AND HELPS YOU STAY ALERT.

# The Just Right Fit



**CHAIR TOO BIG  
DOES NOT ALLOW FOR  
PROPER SEATING  
POSTURE**

**PILLOW BEHIND BACK  
STOOL FOR FOOT  
SUPPORT  
ALLOWS FOR  
90/90/90 POSITION**



**NOT GOOD  
NO SUPPORT  
CHAIR TOO BIG**

**GETTING THERE**



**WE MADE IT...  
FEET SUPPORTED, 2 PILLOWS FOR  
ENOUGH BACK SUPPORT  
HEAD IN NEUTRAL**



# Ergonomic Mindset-Work Athlete



## Sports Athlete

Teams practice 2-4 hours a day

Most sports teams have games 1-2 times a week

Basketball has an 8 month season

Athletes mentally and physically prepare for their sport



## Work Athlete

You work 8-12 hours a day

You work 5-6 days a week

You likely work 11-12 months a year

We want you to be the athlete that trains and practices self care to prevent injuries for work and home tasks



## Be an “Ergo Champ”

- Use ergonomic principles to stay healthy
- Environmental awareness
- Personal awareness: body postures
- Use the right tool for the job
- Continue to train as an industrial athlete
- Contact us for help





RISK CONTROL  
& INSURANCE  
SMARTER INSURANCE  
FOR SMARTER BUSINESS.



New Mexico  
Public Schools  
Insurance  
Authority

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Please visit our website at [www.pomsassoc.com](http://www.pomsassoc.com) or call us at (505)933-6293

# Questions/Discussion



## Ergonomics Program Contact



*"Your best tools are the laws of ergonomics"*

Karen Mestas-Harris, OTR/L, CEAS II

[kmestas@pomsassoc.com](mailto:kmestas@pomsassoc.com)

575-693-3655



# New Mexico Public Schools Insurance Authority



# Thank you for joining us!

Stop at the check-in table to pick up your Certificate of Completion.