New Mexico Public Schools Insurance Authority

Benefits
2023 Spring Budget Workshop
April 12, 2023

New Mexico Public Schools Insurance Authority

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New Mexico Public Schools Insurance Authority

About NMPSIA

The New Mexico Public Schools Insurance Authority (NMPSIA) was created by the NM Legislature in 1986 to serve as a purchasing agency for public school districts, post-secondary educational entities and charter schools. Through NMPSIA, member schools are afforded the opportunity to offer quality employee benefit and risk coverages.

Purpose of act. 22-29-2.

The purpose of the Public School Insurance Authority Act is to provide comprehensive core insurance programs, including reimbursement coverage for the costs of providing due process to students with disabilities, for all participating public schools, school board members, school board retirees and public school employees and retirees by expanding the pool of subscribers to maximize cost containment opportunities for required insurance coverage.

Authority created. 22-29-4

There is created the "public school insurance authority", which is established to provide for group health insurance, other risk-related coverage and due process reimbursement with the exception of the mandatory coverage provided by the risk management division on the effective date of the Public School Insurance Authority Act.

New Mexico Public Schools Insurance Authority

NMPSIA Today

- **School Districts**
  - 88 Mandatory *(Excludes APS)*
- **Charter Schools**
  - 100 Mandatory
- **26 Other Educational Entities**
  - 26 *(Optional)*
- **Monthly Membership**
  - 75,893 Employees and Dependents
  - 39,974 Employees
  - Employees and Dependents by Coverage
    - 44,744 Medical
    - 52,542 Dental
    - 46,078 Vision
    - 12,635 Long-Term Disability
    - 18,540 Additional Life

- **Staff**
  - 11 FTE
- **Board of Directors**
  - **11 Board Members**
    - **Governor Appointees**
      - **Alfred Park, President**
      - **Denise Balderas**
      - **Sammy J. Quintana**
    - **New Mexico Association of School Business Officials**
      - **Chris Parrino, Vice President**
    - **Educational Entities at Large**
      - **Trish Ruiz, Secretary**
    - **AFT-NM**
      - **Tim Crone**
    - **NEA-NM**
      - **Bethany Jarrell**
      - **David Martinez, Jr.**
    - **Public Education Commission**
      - **K.T. Manis**
    - **School Boards Association**
      - **Pauline Jaramillo**
    - **Superintendents' Association**
      - **Travis Dempsey**

New Mexico Public Schools Insurance Authority

HB533

SECTION 2. Section 22-29-10 NMSA 1978 (being Laws 1989, Chapter 373, Section 5, as amended) is amended to read:
22-29-10. GROUP INSURANCE CONTRIBUTIONS

A. Group insurance contributions for school districts, charter schools and participating entities in the authority shall be made as follows:

(1) at least eighty percent of the cost of the insurance of an employee whose annual salary is less than fifty thousand dollars ($50,000);
(2) at least seventy percent of the cost of the insurance of an employee whose annual salary is fifty thousand dollars ($50,000) or more but less than sixty thousand dollars ($60,000); and
(3) at least sixty percent of the cost of the insurance of an employee whose annual salary is sixty thousand dollars ($60,000) or more.

B. Within available revenue, school districts, charter schools and participating entities in the authority may contribute up to one hundred percent of the cost of the insurance of all employees.

New Mexico Public Schools Insurance Authority

HB533

Employer Contributions Effective July 1, 2023
Employer Contributions Calculated on Base Annual Salary
Employer Contribution Requirements set forth in NM State Statute

Employer Contribution	
Salary Less Than $50,000	80%
Salary $50,000 up to $59,999	70%
Salary $60,000 and over	60%

New Mexico Public Schools Insurance Authority

Benefits Premium Rate History

Plan Year	Rate Increase
2014-2015	Medical 1.5%
2015-2016	Medical 4.0%
2016-2017	Medical High Option 8.30% Medical Low Option 7.15%
2017-2018	Medical High Option/HMO 3.98% Medical Low Option 1.82%
2018-2019	Medical High Option/EPO 4.0% Medical Low Option -0.7%
2019-2020	Medical High Option/EPO 5.9% Medical Low Option 3.1% Dental 5.0%
2020-2021	Medical High Option/EPO 6.0% Medical Low Option 2.1%
2021-2022	Medical High Option/EPO 6.0% Medical Low Option 3.6%
2022-2023	Medical High Option/EPO 6.0% Medical Low Option 3.2%
2023-2024	**Medical High Option 7.24%** **Medical Low Option 7.24%** **Medical EPO Option 7.24%**

New Mexico Public Schools Insurance Authority

NMPSIA Medical Premiums Effective October 1, 2023

MEDICAL COVERAGES *Employer contributes premium (see reverse side)*	Single	Two-Party	Family
Blue Cross Blue Shield New Mexico – High Option	$922.70	$1,754.78	$2,343.72
Blue Cross Blue Shield New Mexico – Low Option	$639.72	$1,216.66	$1,625.08
Blue Cross Blue Shield New Mexico – Exclusive Provider Organization (EPO) Option*	$830.40	$1,579.26	$2,109.30
Cigna – High Option	$881.02	$1,700.74	$2,279.56
Cigna – Low Option	$613.70	$1,184.68	$1,587.88
Presbyterian – High Option	$746.14	$1,566.80	$2,089.24
Presbyterian – Low Option	$517.40	$1,086.36	$1,448.56

New Mexico Public Schools Insurance Authority

NMPSIA Benefits Enrollment

EASI
Erisa Administrative Services, Inc.

Erisa Administrative Services, Inc. (EASI)

NMPSIA Employee Benefits Administration

Erisa Administrative Services, Inc.
P.O. Box 9054
Santa Fe, NM 87504-9054
Santa Fe: (505) 988-4974 ● Toll Free: (800) 233-3164
Email: sf@easitpa.com
Kathy Payanes: 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

NMPSIA Benefits Enrollment

Starts With a Properly Completed Form

Learn how at https://nmpsia.com/monthlyTopicTrainings.html

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

NMPSIA Benefits Enrollment

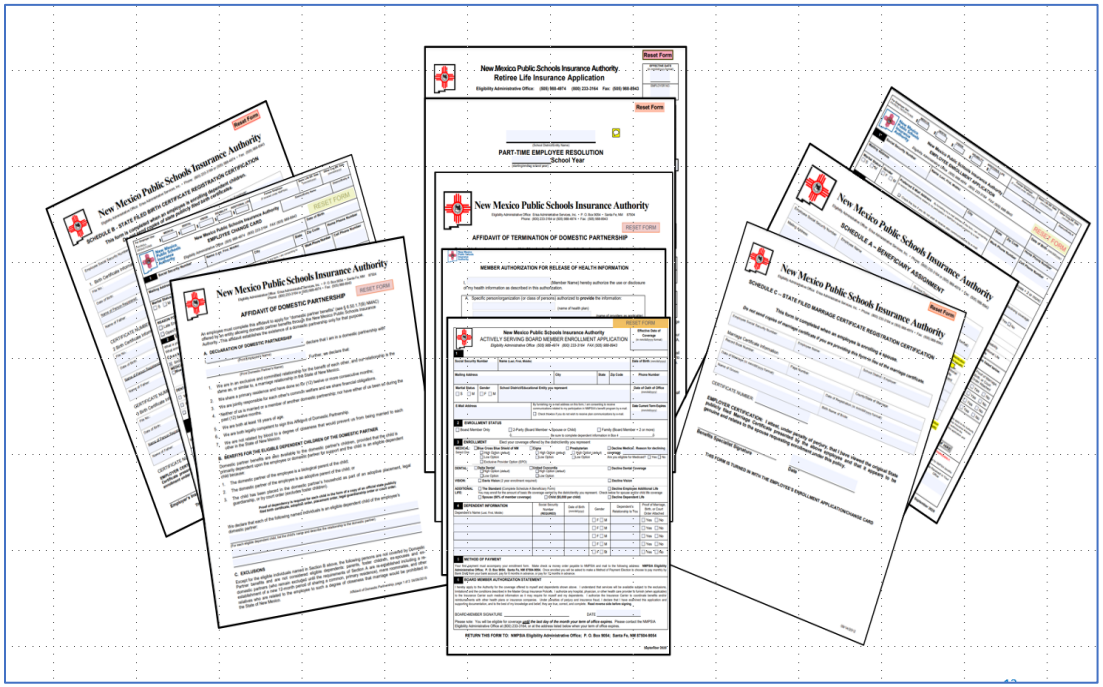
Completing NMPSIA Forms

Important Documents and Forms +

- Employee Enrollment Application
- Board Member Enrollment Application
- Schedule A for Beneficiary Designation
- Schedule B for Birth Registration
- Schedule C for Marriage Registration
- Beneficiary Questions & Answers
- Change Card
- Affidavit for Domestic Partner
- Termination of Domestic Partner
- Retiree life Insurance Application (under age 65)
- Options for Continuing Life Insurance Due to Retirement
- Release of Health Information
- Sample Loss of Coverage Form
- Part Time Resolution Template

Found at Employers Tab and

choose NMPSIA Benefits Enrollment & Forms



New Mexico Public Schools Insurance Authority

EASI
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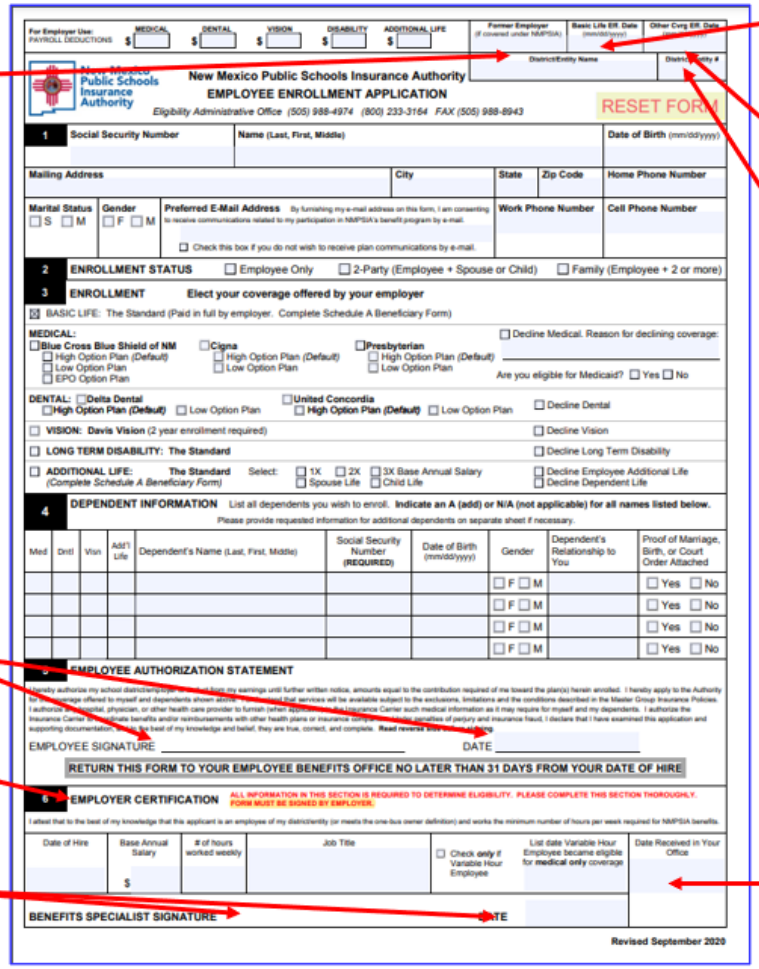
NMPSIA Benefits Enrollment

Employee Enrollment Application



New Mexico Public Schools Insurance Authority
EMPLOYEE ENROLLMENT APPLICATION
Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943
RESET FORM

1 Social Security Number | Name (Last, First, Middle) | Date of Birth (mm/dd/yyyy)
Mailing Address | City | State | Zip Code | Home Phone Number
Marital Status ☐S ☐M | Gender ☐F ☐M | Preferred E-Mail Address | Work Phone Number | Cell Phone Number
☐ Check this box if you do not wish to receive plan communications by e-mail.

2 ENROLLMENT STATUS ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

3 ENROLLMENT Elect your coverage offered by your employer
☒ BASIC LIFE: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form)
MEDICAL: ☐ Blue Cross Blue Shield of NM (☐ High Option Plan (Default) ☐ Low Option Plan ☐ EPO Option Plan) ☐ Cigna (☐ High Option Plan (Default) ☐ Low Option Plan) ☐ Presbyterian (☐ High Option Plan (Default) ☐ Low Option Plan) ☐ Decline Medical. Reason for declining coverage: ____ Are you eligible for Medicaid? ☐ Yes ☐ No
DENTAL: ☐ Delta Dental ☐ High Option Plan (Default) ☐ Low Option Plan ☐ United Concordia ☐ High Option Plan (Default) ☐ Low Option Plan ☐ Decline Dental
☐ VISION: Davis Vision (2 year enrollment required) ☐ Decline Vision
☐ LONG TERM DISABILITY: The Standard ☐ Decline Long Term Disability
☐ ADDITIONAL LIFE: The Standard (Complete Schedule A Beneficiary Form) Select: ☐ 1X ☐ 2X ☐ 3X Base Annual Salary ☐ Spouse Life ☐ Child Life ☐ Decline Employee Additional Life ☐ Decline Dependent Life

4 DEPENDENT INFORMATION List all dependents you wish to enroll. Indicate an A (add) or N/A (not applicable) for all names listed below.
Please provide requested information for additional dependents on separate sheet if necessary.

Med	Dntl	Vsn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, or Court Order Attached
							☐F ☐M		☐Yes ☐No
							☐F ☐M		☐Yes ☐No
							☐F ☐M		☐Yes ☐No
							☐F ☐M		☐Yes ☐No

5 EMPLOYEE AUTHORIZATION STATEMENT
I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. 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 conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined this application and supporting documentation, and to the best of my knowledge and belief, they are true, correct, and complete. Read reverse side for rights
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 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-bus owner definition) 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	☐ Check only if Variable Hour Employee	List date Variable Hour Employee became eligible for medical only coverage	Date Received in Your Office
	$					

BENEFITS SPECIALIST SIGNATURE _____ DATE _____
Revised September 2020

District Name

Section 4 Dependent Information reflects selection of **Section 2** Enrollment Status

Employee **Must** sign and date

Employer is responsible to complete the EMPLOYER CERTIFICATION section after verifying the form is completed in its entirety

Form **Must** be signed and dated by employer

Basic Life is **always** effective 1st of the month following the employee's date of hire

No retroactive effective dates allowed

District Number

NOTE: *Evidence of White-Out used or any highlighted areas on any document requires an amended document*

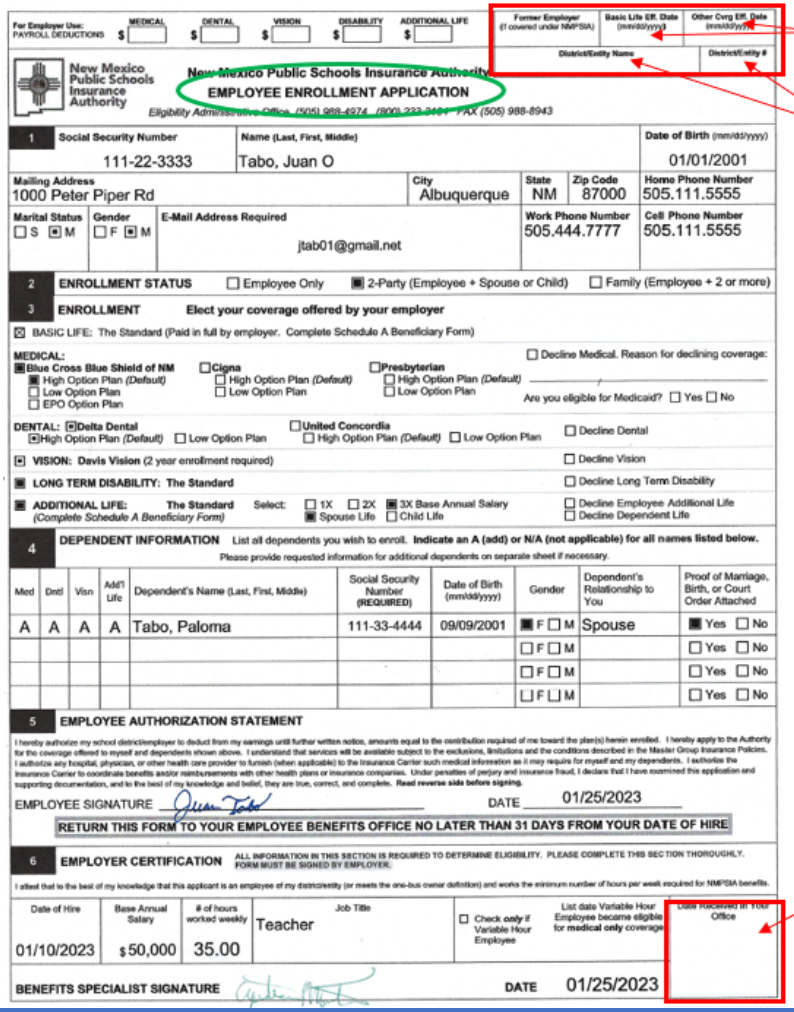
Date Received in Your Office must be stamped **not written**

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

NMPSIA Benefits Enrollment

What's wrong with this form?



For Employer Use: PAYROLL DEDUCTIONS — MEDICAL $ | DENTAL $ | VISION $ | DISABILITY $ | ADDITIONAL LIFE $

Former Employer (if covered under NMPSIA) | Basic Life Eff. Date (mm/dd/yyyy) | Other Cvrg Eff. Date (mm/dd/yyyy)

District/Entity Name | District/Entity #

New Mexico Public Schools Insurance Authority

EMPLOYEE ENROLLMENT APPLICATION

Eligibility Administrative Office (505) 988-6974 (800) 233-3484 FAX (505) 988-8943

1 Social Security Number	Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)
111-22-3333	Tabo, Juan O	01/01/2001

Mailing Address	City	State	Zip Code	Home Phone Number
1000 Peter Piper Rd	Albuquerque	NM	87000	505.111.5555

Marital Status	Gender	E-Mail Address Required	Work Phone Number	Cell Phone Number
☐ S ☒ M	☐ F ☒ M	jtab01@gmail.net	505.444.7777	505.111.5555

2 ENROLLMENT STATUS ☐ Employee Only ■ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

3 ENROLLMENT Elect your coverage offered by your employer

☒ BASIC LIFE: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form)

MEDICAL: ■ Blue Cross Blue Shield of NM ■ High Option Plan (Default) ☐ Low Option Plan ☐ EPO Option Plan | ☐ Cigna ☐ High Option Plan (Default) ☐ Low Option Plan | ☐ Presbyterian ☐ High Option Plan (Default) ☐ Low Option Plan | ☐ Decline Medical. Reason for declining coverage: _____ Are you eligible for Medicaid? ☐ Yes ☐ No

DENTAL: ☒ Delta Dental ☒ High Option Plan (Default) ☐ Low Option Plan | ☐ United Concordia ☐ High Option Plan (Default) ☐ Low Option Plan | ☐ Decline Dental

☒ VISION: Davis Vision (2 year enrollment required) ☐ Decline Vision

■ LONG TERM DISABILITY: The Standard ☐ Decline Long Term Disability

■ ADDITIONAL LIFE: The Standard (Complete Schedule A Beneficiary Form) Select: ☐ 1X ☐ 2X ■ 3X Base Annual Salary ■ Spouse Life ☐ Child Life | ☐ Decline Employee Additional Life ☐ Decline Dependent Life

4 DEPENDENT INFORMATION List all dependents you wish to enroll. **Indicate an A (add) or N/A (not applicable) for all names listed below.**
Please provide requested information for additional dependents on separate sheet if necessary.

Med	Dntl	Visn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, or Court Order Attached
A	A	A	A	Tabo, Paloma	111-33-4444	09/09/2001	■ F ☐ M	Spouse	■ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No

5 EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. 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 conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined 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 Juan Tabo DATE 01/25/2023

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 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-bus owner definition) 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	☐ Check only if Variable Hour Employee	List date Variable Hour Employee became eligible for medical only coverage	Date Received in Your Office
01/10/2023	$50,000	35.00	Teacher			

BENEFITS SPECIALIST SIGNATURE _____ DATE 01/25/2023

Basic Life and Other Coverage Effective Dates not completed

District/Entity Name and District # is missing

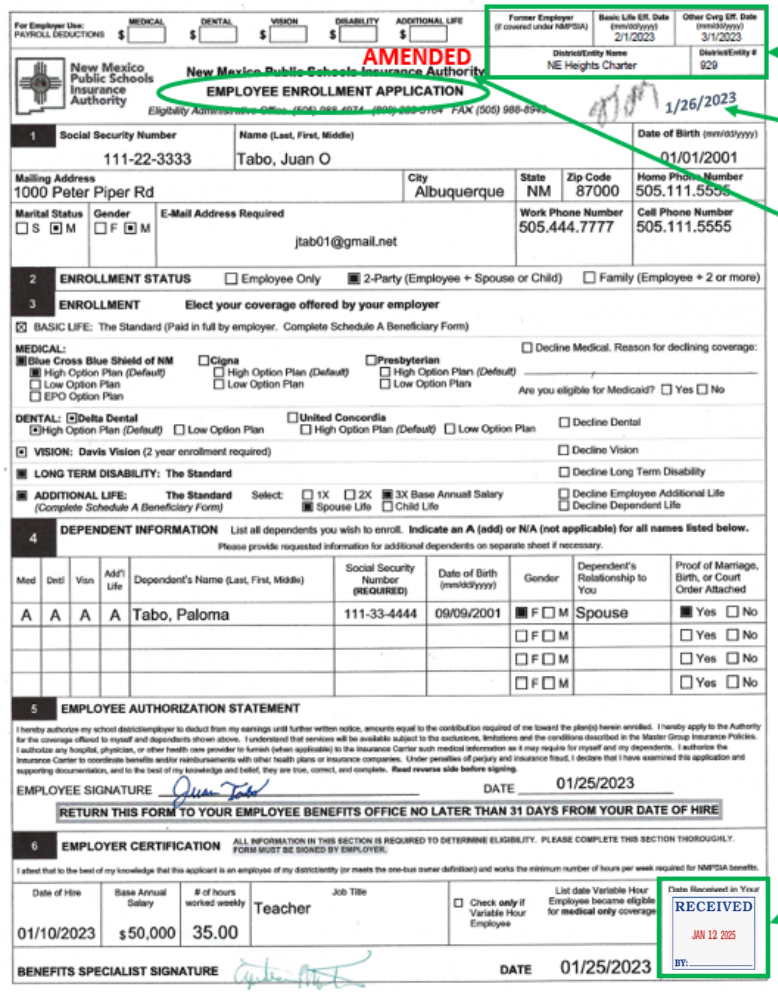
Date Received in Your Office must be stamped **not written**

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

NMPSIA Benefits Enrollment

The Amended and Correct Form



AMENDED

New Mexico Public Schools Insurance Authority

EMPLOYEE ENROLLMENT APPLICATION

Eligibility Administrative Office: (505) 988-6974 (800) 233-3164 FAX (505) 988-6945

1/26/2023

Former Employer (If covered under NMPSIA)	Basic Life Eff. Date (mm/dd/yyyy)	Other Cvrg Eff. Date (mm/dd/yyyy)
	2/1/2023	3/1/2023
District/Entity Name: NE Heights Charter		District/Entity #: 929

1 Social Security Number	Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)
111-22-3333	Tabo, Juan O	01/01/2001

Mailing Address	City	State	Zip Code	Home Phone Number
1000 Peter Piper Rd	Albuquerque	NM	87000	505.111.5555

Marital Status	Gender	E-Mail Address Required	Work Phone Number	Cell Phone Number
☐ S ☒ M	☐ F ☒ M	jtab01@gmail.net	505.444.7777	505.111.5555

2 ENROLLMENT STATUS ☐ Employee Only ☒ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

3 ENROLLMENT Elect your coverage offered by your employer

☒ BASIC LIFE: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form)

MEDICAL: ☒ Blue Cross Blue Shield of NM ☒ High Option Plan (Default) ☐ Low Option Plan ☐ EPO Option Plan ☐ Cigna ☐ High Option Plan (Default) ☐ Low Option Plan ☐ Presbyterian ☐ High Option Plan (Default) ☐ Low Option Plan ☐ Decline Medical. Reason for declining coverage: Are you eligible for Medicaid? ☐ Yes ☐ No

DENTAL: ☒ Delta Dental ☒ High Option Plan (Default) ☐ Low Option Plan ☐ United Concordia ☐ High Option Plan (Default) ☐ Low Option Plan ☐ Decline Dental

☒ VISION: Davis Vision (2 year enrollment required) ☐ Decline Vision

☒ LONG TERM DISABILITY: The Standard ☐ Decline Long Term Disability

☒ ADDITIONAL LIFE: The Standard (Complete Schedule A Beneficiary Form) Select: ☐ 1X ☐ 2X ☒ 3X Base Annual Salary ☒ Spouse Life ☐ Child Life ☐ Decline Employee Additional Life ☐ Decline Dependent Life

4 DEPENDENT INFORMATION List all dependents you wish to enroll. Indicate an A (add) or N/A (not applicable) for all names listed below. Please provide requested information for additional dependents on separate sheet if necessary.

Med	Dntl	Vsn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, or Court Order Attached
A	A	A	A	Tabo, Paloma	111-33-4444	09/09/2001	☒ F ☐ M	Spouse	☒ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No

5 EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. 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 conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined 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 Juan Tabo DATE 01/25/2023

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 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-bus owner definition) 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	☐ Check only if Variable Hour Employee	List date Variable Hour Employee became eligible for medical only coverage	Date Received in Your
01/10/2023	$50,000	35.00	Teacher			RECEIVED JAN 12 2025 BY:

BENEFITS SPECIALIST SIGNATURE DATE 01/25/2023

Basic Life and Other Coverage Effective Dates are completed and District/Entity Name and # have been added

Both employer and employee have initialed and dated the updates

The word "AMENDED" MUST be on form to note that this is an amendment to the previous form

Date Received in Your Office has been stamped

NMPSIA Benefits Enrollment

Employee Change Card

District/Entity Name and District/Entity #

Reason for Change

Section 3 Dependent Information reflects selection in **Section 2** Enrollment Status

Removing ineligible dependents may also apply to any ancillary benefits your employer offers

Employer is responsible to complete the EMPLOYER CERTIFICATION section after verifying the form is completed in its entirety

Form **Must** be signed and dated by employer

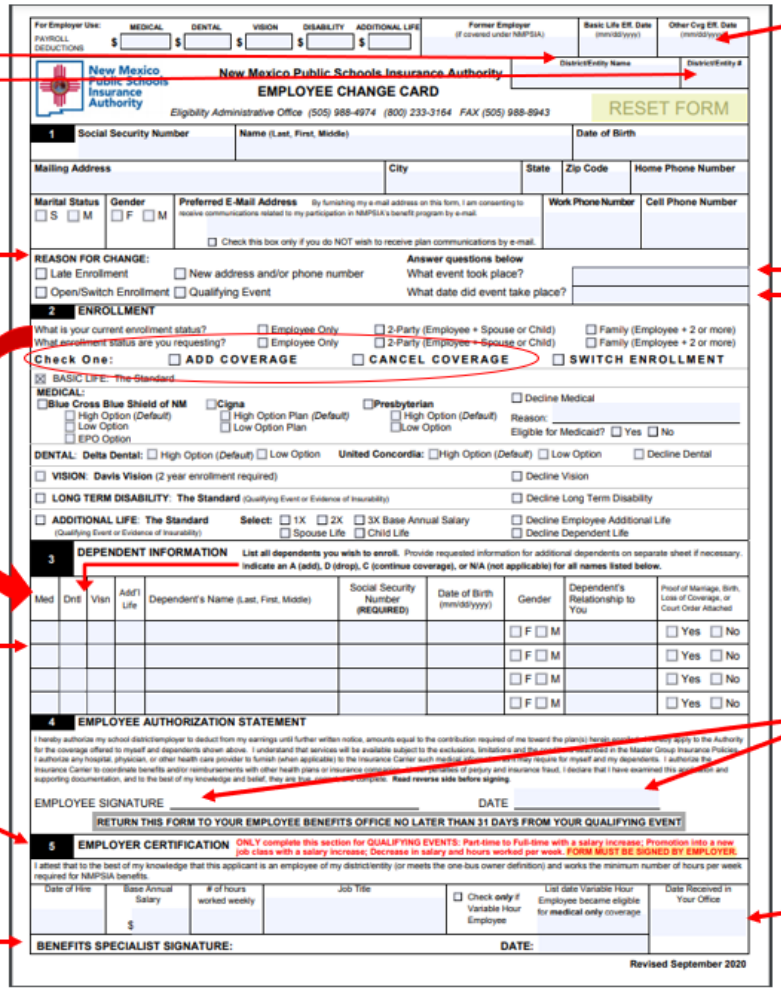
Other coverage effective date/end date

What Event took place?
What date did event take place?

NOTE: *Evidence of White-Out used or any highlighted areas on any document requires an amended document*

Employee **Must** sign and date (unless Basic Life only or Resignation/Separation)

Date Received in Your Office must be stamped **not written**



New Mexico Public Schools Insurance Authority

EMPLOYEE CHANGE CARD

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

RESET FORM

1 Social Security Number | Name (Last, First, Middle) | Date of Birth

Mailing Address | City | State | Zip Code | Home Phone Number

Marital Status | Gender | Preferred E-Mail Address | Work Phone Number | Cell Phone Number

REASON FOR CHANGE:
Late Enrollment | New address and/or phone number
Open/Switch Enrollment | Qualifying Event

Answer questions below
What event took place?
What date did event take place?

2 ENROLLMENT

What is your current enrollment status? Employee Only | 2-Party (Employee + Spouse or Child) | Family (Employee + 2 or more)
What enrollment status are you requesting? Employee Only | 2-Party (Employee + Spouse or Child) | Family (Employee + 2 or more)

Check One: ADD COVERAGE | CANCEL COVERAGE | SWITCH ENROLLMENT

BASIC LIFE: The Standard

MEDICAL: Blue Cross Blue Shield of NM (High Option (Default), Low Option, EPO Option) | Cigna (High Option Plan (Default), Low Option Plan) | Presbyterian (High Option (Default), Low Option) | Decline Medical | Reason: | 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 (2 year enrollment required) | Decline Vision

LONG TERM DISABILITY: The Standard (Qualifying Event or Evidence of Insurability) | Decline Long Term Disability

ADDITIONAL LIFE: The Standard (Qualifying Event or Evidence of Insurability) | Select: 1X 2X 3X Base Annual Salary, Spouse Life, Child Life | Decline Employee Additional 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 an A (add), D (drop), C (continue coverage), or N/A (not applicable) for all names listed below.

Med	Dntl	Visn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached
							F M		Yes No
							F M		Yes No
							F M		Yes No
							F M		Yes No

4 EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. I 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 [illegible] described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information and [illegible] they require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies [illegible] penalties of perjury and insurance fraud. I declare that I have examined 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 _____ DATE _____

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

5 EMPLOYER CERTIFICATION ONLY complete this section for QUALIFYING EVENTS: Part-time to Full-time with a salary increase; Promotion into a new job class with a salary increase; Decrease in salary and hours worked per week. 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-bus owner definition) 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	Check only if Variable Hour Employee	List date Variable Hour Employee became eligible for medical only coverage	Date Received in Your Office
	$					

BENEFITS SPECIALIST SIGNATURE: DATE:

Revised September 2020

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

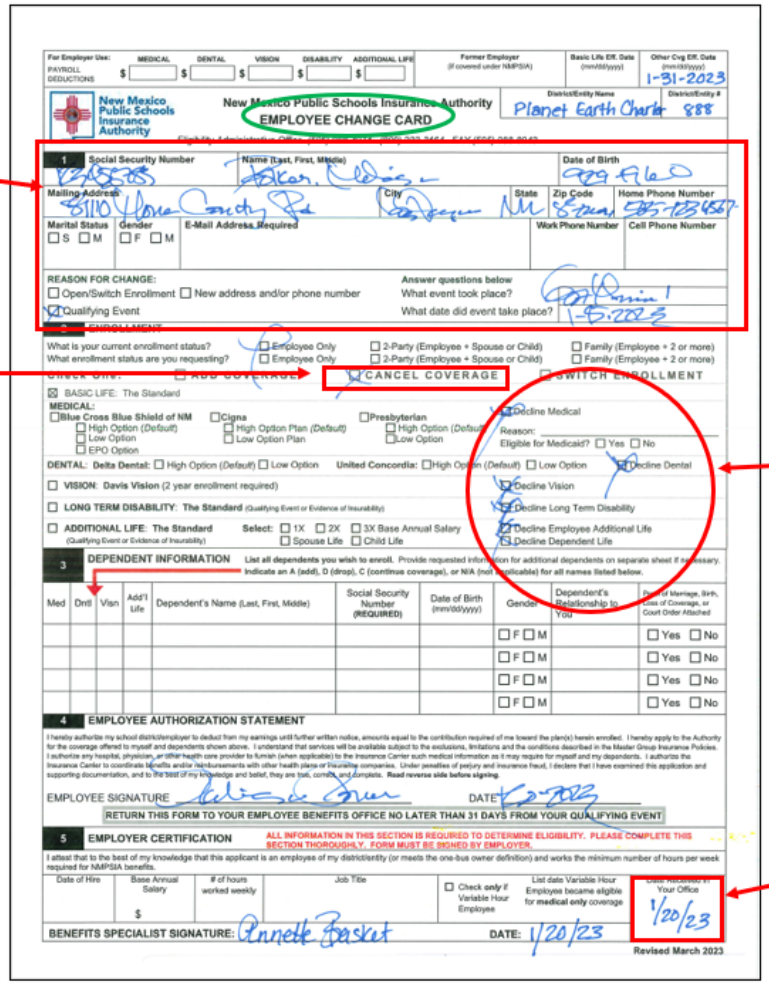
NMPSIA Benefits Enrollment

What's wrong with this form?

Illegible and Incomplete
Not clear enough to be read

Employee is electing to Cancel Coverage

Employee should select only the coverages they are canceling



Employee is canceling coverage **NOT Declining** coverage

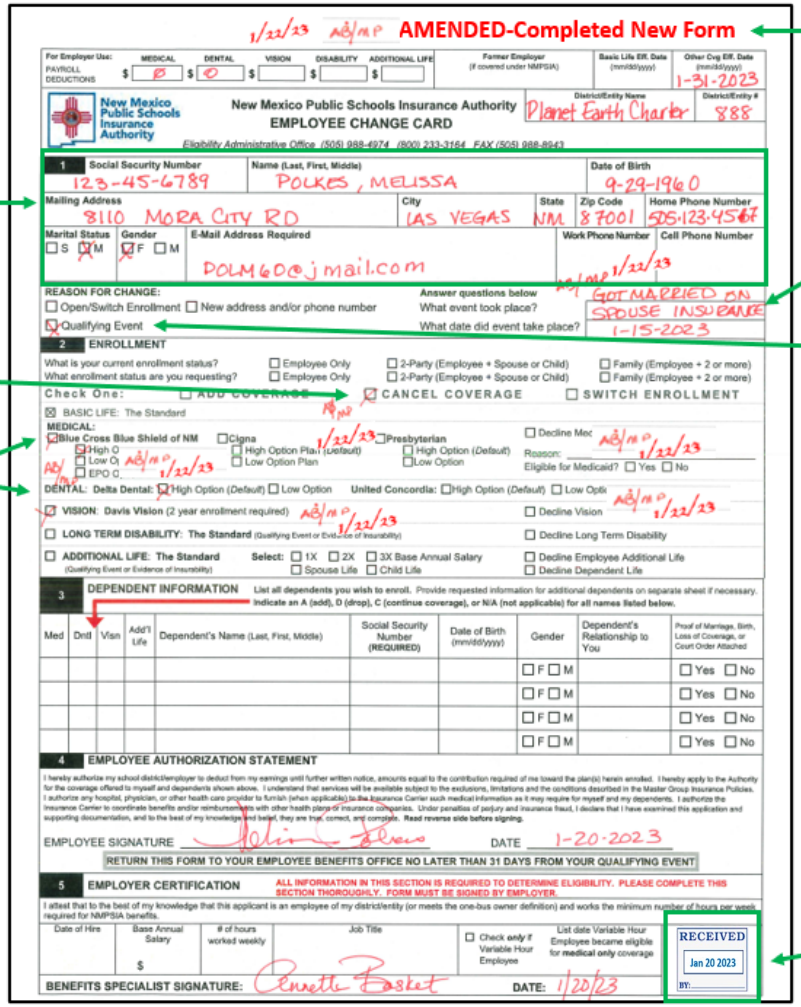
Date Received in Your Office must be stamped **not written**

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

NMPSIA Benefits Enrollment

The Amended and Correct Form



1/22/23 AB/MP **AMENDED-Completed New Form**

New Mexico Public Schools Insurance Authority
EMPLOYEE CHANGE CARD
Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943

Former Employer (If covered under NMPSIA)	Basic Life Eff. Date (mm/dd/yyyy)	Other Cvg Eff. Date (mm/dd/yyyy)
		1-31-2023

District/Entity Name: Planet Earth Charter — District/Entity #: 888

1 Social Security Number: 123-45-6789 — Name (Last, First, Middle): POLKES, MELISSA — Date of Birth: 9-29-1960

Mailing Address: 8110 MORA CITY RD — City: LAS VEGAS — State: NM — Zip Code: 87001 — Home Phone Number: 505-123-4567

Marital Status: ☐S ☒M — Gender: ☒F ☐M — E-Mail Address Required: POLM60@jmail.com — Work Phone Number — Cell Phone Number — AB/MP 1/22/23

REASON FOR CHANGE:
☐ Open/Switch Enrollment ☐ New address and/or phone number
☒ Qualifying Event

Answer questions below
What event took place? GOT MARRIED ON SPOUSE INSURANCE
What date did event take place? 1-15-2023

2 ENROLLMENT

What is your current enrollment status? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)
What enrollment status are you requesting? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

Check One: ☐ ADD COVERAGE ☒ CANCEL COVERAGE ☐ SWITCH ENROLLMENT

☒ BASIC LIFE: The Standard

MEDICAL: ☒ Blue Cross Blue Shield of NM ☐ Cigna ☐ Presbyterian ☐ Decline Med AB/MP 1/22/23
☒ High O ☐ High Option Plan (Default) ☐ High Option (Default)
☐ Low O ☐ Low Option Plan ☐ Low Option
☐ EPO O AB/MP 1/22/23 — Reason: — Eligible for Medicaid? ☐ Yes ☐ No

DENTAL: Delta Dental: ☒ High Option (Default) ☐ Low Option — United Concordia: ☐ High Option (Default) ☐ Low Optio AB/MP 1/22/23

☒ VISION: Davis Vision (2 year enrollment required) AB/MP 1/22/23 ☐ Decline Vision AB/MP 1/22/23

☐ LONG TERM DISABILITY: The Standard (Qualifying Event or Evidence of Insurability) ☐ Decline Long Term Disability

☐ ADDITIONAL LIFE: The Standard (Qualifying Event or Evidence of Insurability) — Select: ☐ 1X ☐ 2X ☐ 3X Base Annual Salary ☐ Spouse Life ☐ Child Life — ☐ Decline Employee Additional 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 an A (add), D (drop), C (continue coverage), or N/A (not applicable) for all names listed below.

Med	Dntl	Vsn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached
							☐F ☐M		☐ Yes ☐ No
							☐F ☐M		☐ Yes ☐ No
							☐F ☐M		☐ Yes ☐ No
							☐F ☐M		☐ Yes ☐ No

4 EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. 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 conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined 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 [signature] DATE 1-20-2023

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 attest that to the best of my knowledge that this applicant is an employee of my district/entity (or meets the one-bus owner definition) 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	Check only if Variable Hour Employee	List date Variable Hour Employee became eligible for medical only coverage
	$			☐	

BENEFITS SPECIALIST SIGNATURE: Cinette Baskett DATE: 1/20/23

RECEIVED Jan 20 2023 BY:

Employee information is legible and complete

Employee is electing to Cancel Coverage

Employee has selected the coverages she wants to cancel

The word "AMENDED" MUST be on form to note that this is an amendment to previous form

Employee has selected a Qualifying Event due to Marriage as the Reason for Change

Employer and employee have initialed and dated the updates

Date Received in Your Office has been stamped

NMPSIA Benefits Enrollment

What's wrong with this form?

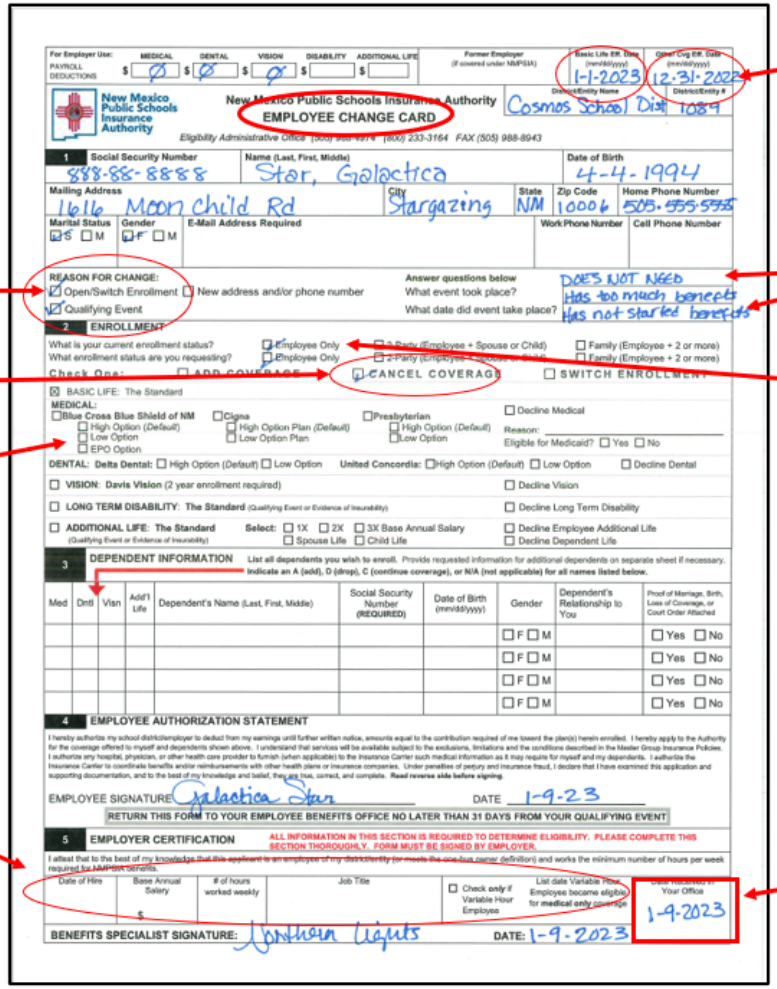
New Hire Enrollment or Change of Status?

Open/Switch Enrollment or Qualifying Event?

Employee is electing to Cancel Coverage?

Which coverage(s) does employee want to cancel?

EMPLOYER CERTIFICATION section is incomplete for New Hire, Change?



Other Coverage End date is prior to Basic Life Start Date?

Employee is requesting to cancel coverage(s) that have not started?

NO CHANGE:
What is current enrollment status? Employee Only
What enrollment status are you requesting? Employee Only

Date Received in Your Office must be stamped **not written**

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

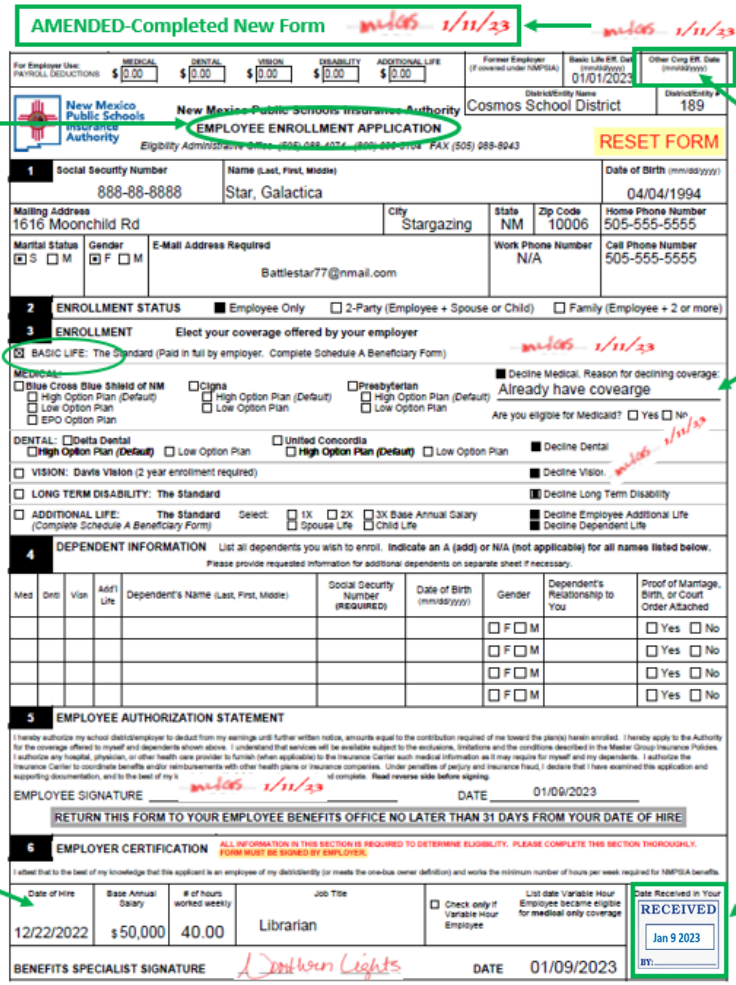
NMPSIA Benefits Enrollment

The Amended and Correct Form

And the winner is:
Employee New Hire Enrollment Basic Life ONLY

The Change Card was to end enrollment before it started

Employer and employee have initialed and dated the updates



AMENDED-Completed New Form mdcs 1/11/23

New Mexico Public Schools Insurance Authority

EMPLOYEE ENROLLMENT APPLICATION

RESET FORM

Cosmos School District

1 Social Security Number: 888-88-8888 | Name (Last, First, Middle): Star, Galactica | Date of Birth: 04/04/1994

Mailing Address: 1616 Moonchild Rd | City: Stargazing | State: NM | Zip Code: 10006 | Home Phone Number: 505-555-5555

Marital Status: S | Gender: F | E-Mail Address Required: Battlestar77@nmail.com | Work Phone Number: N/A | Cell Phone Number: 505-555-5555

2 ENROLLMENT STATUS: Employee Only

3 ENROLLMENT — Elect your coverage offered by your employer

BASIC LIFE: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form) mdcs 1/11/23

MEDICAL: Decline Medical. Reason for declining coverage: Already have coverage

Are you eligible for Medicaid? Yes No

DENTAL: Decline Dental mdcs 1/11/23

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

LONG TERM DISABILITY: The Standard Decline Long Term Disability

ADDITIONAL LIFE: The Standard Decline Employee Additional Life Decline Dependent Life

4 DEPENDENT INFORMATION — List all dependents you wish to enroll. Indicate an A (add) or N/A (not applicable) for all names listed below.

Med	Dntl	Vsn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number (REQUIRED)	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, or Court Order Attached
							F M		Yes No
							F M		Yes No
							F M		Yes No
							F M		Yes No

5 EMPLOYEE AUTHORIZATION STATEMENT

EMPLOYEE SIGNATURE mdcs 1/11/23 DATE 01/09/2023

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 DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY EMPLOYER.

Date of Hire	Base Annual Salary	# of hours worked weekly	Job Title	Check only if Variable Hour Employee	List date Variable Hour Employee became eligible for medical only coverage
12/22/2022	$50,000	40.00	Librarian		

BENEFITS SPECIALIST SIGNATURE Deathwen Lights DATE 01/09/2023

Date Received in Your Office: RECEIVED Jan 9 2023 BY:

Revised March 2022

The word "AMENDED" MUST be on form to note that this is an amendment to previous form

Other Covg Eff Date is not applicabl in this case and both the employer and employee have initialed and dated this area to confirm

Employee is declining all coverage

Employer Certification has been completed and we now know the Date of Hire, Base Annual Salary, # of hours worked weekly and Job Title

Date Received in Your Office has been stamped

New Mexico Public Schools Insurance Authority

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NMPSIA Benefits Enrollment

Benefits Enrollment is Reinforced with Supportive Documentation

New Mexico Public Schools Insurance Authority

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NMPSIA Benefits Enrollment

Supportive Documentation
Proof of Marriage

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

NMPSIA Benefits Enrollment

Supportive Documentation
Proof of Birth for Dependent Children

New Mexico Public Schools Insurance Authority

NMPSIA Benefits Enrollment

EASI
Erisa Administrative Services, Inc.

Found on Page 14 in Program Guide

Supportive Documentation
Proof of Loss of Coverage

Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage.
This may include an **involuntary loss** of medical, dental, vision or life insurance due to:

- Reduction in hours worked
- Resignation, termination, or retirement from employment
- Divorce, annulment, or termination of domestic partnership
- No longer meet eligibility requirements for insurance
- Exhaustion of COBRA
- Death

Be advised: voluntary cancelling other coverage or non-compliance to maintain other coverage is not considered a qualifying event.

IMPORTANT: PROOF OF INVOLUNTARY LOSS REQUIRED
Verifiable proof of involuntary loss is required to be provided to your employer's benefits office. A loss of coverage letter MUST contain the following information: *(See your employer's benefits office for an example.)*

- Name and contact information of employer and/or entity who maintained the insurance coverage lost.
- Who lost coverage?
- What type of coverage was lost?
- What date coverage ended.
- Why coverage was lost.

Unacceptable forms of proof of loss of coverage include:

- Certificate of Creditable Coverage
- COBRA Qualifying Event Letter
- Divorce decree

New Mexico Public Schools Insurance Authority

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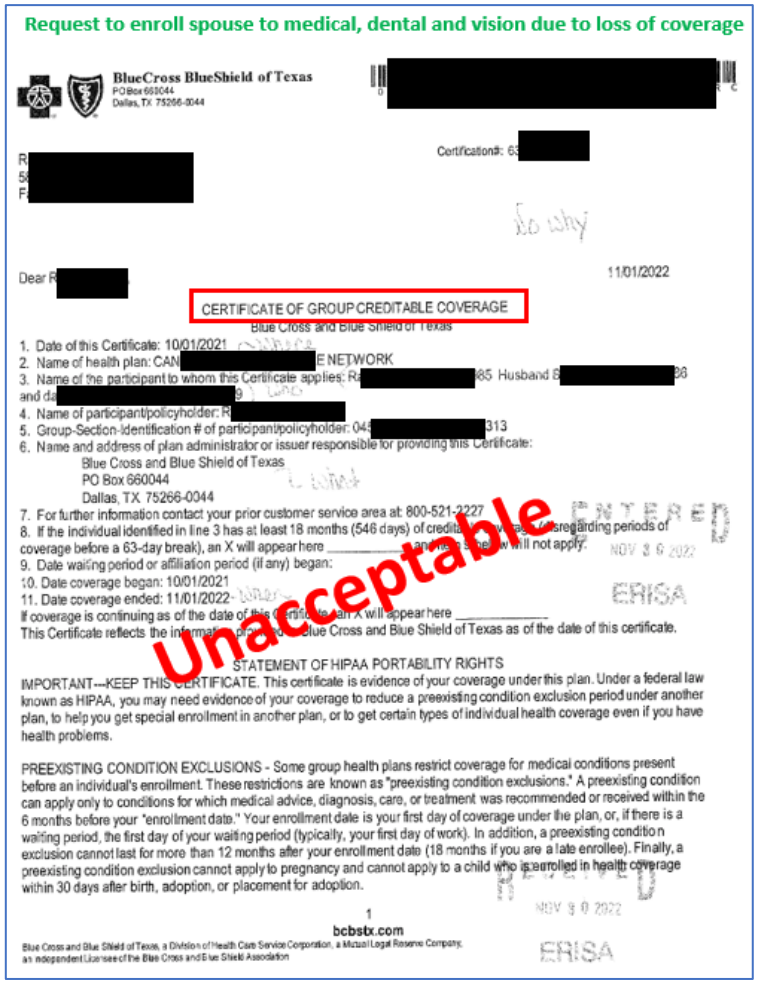
NMPSIA Benefits Enrollment

Supportive Documentation - Proof of Loss of Coverage



Request to enroll spouse to medical, dental and vision due to loss of coverage

BlueCross BlueShield of Texas
PO Box 660044
Dallas, TX 75266-0044

[redacted]

Certificate#: [redacted]

Dear [redacted]

11/01/2022

CERTIFICATE OF GROUP CREDITABLE COVERAGE
Blue Cross and Blue Shield of Texas

1. Date of this Certificate: 10/01/2021
2. Name of health plan: CAN[redacted]E NETWORK
3. Name of the participant to whom this Certificate applies: R[redacted]85 Husband B[redacted]96 and da[redacted]
4. Name of participant/policyholder: R[redacted]
5. Group-Section-Identification # of participant/policyholder: 04[redacted]313
6. Name and address of plan administrator or issuer responsible for providing this Certificate:
   Blue Cross and Blue Shield of Texas
   PO Box 660044
   Dallas, TX 75266-0044
7. For further information contact your prior customer service area at: 800-521-2227
8. If the individual identified in line 3 has at least 18 months (546 days) of credit[redacted] regarding periods of coverage before a 63-day break), an X will appear here _____ and [redacted] will not apply.
9. Date waiting period or affiliation period (if any) began:
10. Date coverage began: 10/01/2021
11. Date coverage ended: 11/01/2022-
If coverage is continuing as of the date of this certificate, an X will appear here _____
This Certificate reflects the information [redacted] Blue Cross and Blue Shield of Texas as of the date of this certificate.

ENTERED NOV 3 0 2022 ERISA

Unacceptable

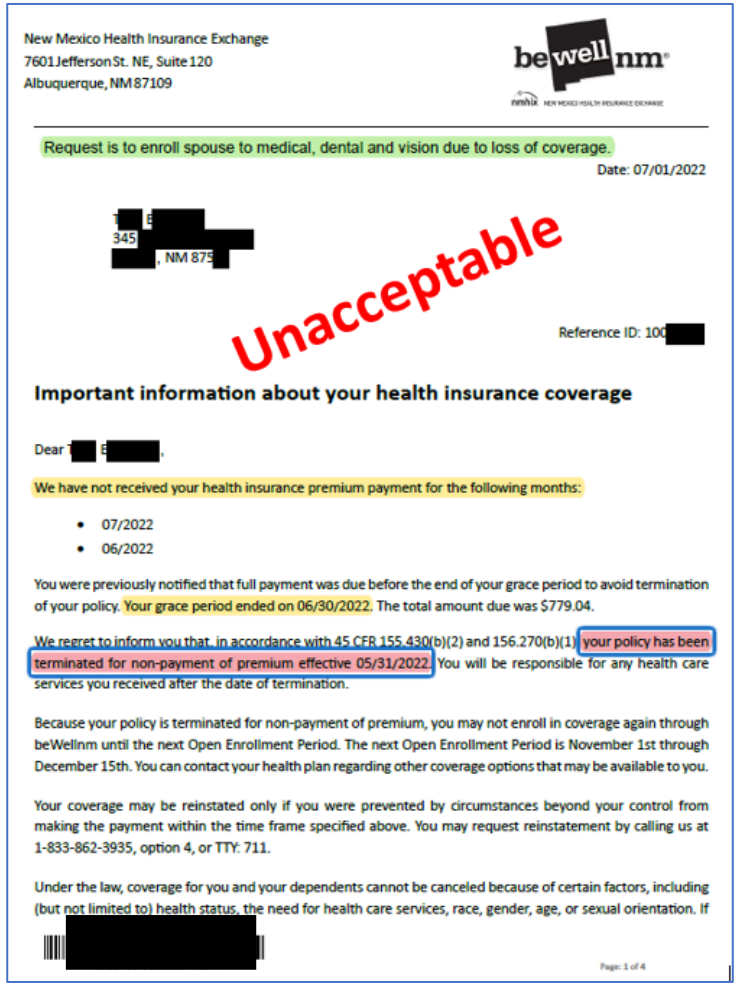
STATEMENT OF HIPAA PORTABILITY RIGHTS

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 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.

RECEIVED NOV 3 0 2022 ERISA

1
bcbstx.com
Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



New Mexico Health Insurance Exchange
7601 Jefferson St. NE, Suite 120
Albuquerque, NM 87109

beWellnm

Request is to enroll spouse to medical, dental and vision due to loss of coverage.

Date: 07/01/2022

[redacted]
345
[redacted], NM 875[redacted]

Unacceptable

Reference ID: 100[redacted]

Important information about your health insurance coverage

Dear [redacted]

We have not received your health insurance premium payment for the following months:

- 07/2022
- 06/2022

You were previously notified that full payment was due before the end of your grace period to avoid termination of your policy. Your grace period ended on 06/30/2022. The total amount due was $779.04.

We regret to inform you that, in accordance with 45 CFR 155.430(b)(2) and 156.270(b)(1), your policy has been terminated for non-payment of premium effective 05/31/2022. You will be responsible for any health care services you received after the date of termination.

Because your policy is terminated for non-payment of premium, you may not enroll in coverage again through beWellnm until the next Open Enrollment Period. The next Open Enrollment Period is November 1st through December 15th. You can contact your health plan regarding other coverage options that may be available to you.

Your coverage may be reinstated only if you were prevented by circumstances beyond your control from making the payment within the time frame specified above. You may request reinstatement by calling us at 1-833-862-3935, option 4, or TTY: 711.

Under the law, coverage for you and your dependents cannot be canceled because of certain factors, including (but not limited to) health status, the need for health care services, race, gender, age, or sexual orientation. If

[redacted]

Page: 1 of 4

New Mexico Public Schools Insurance Authority

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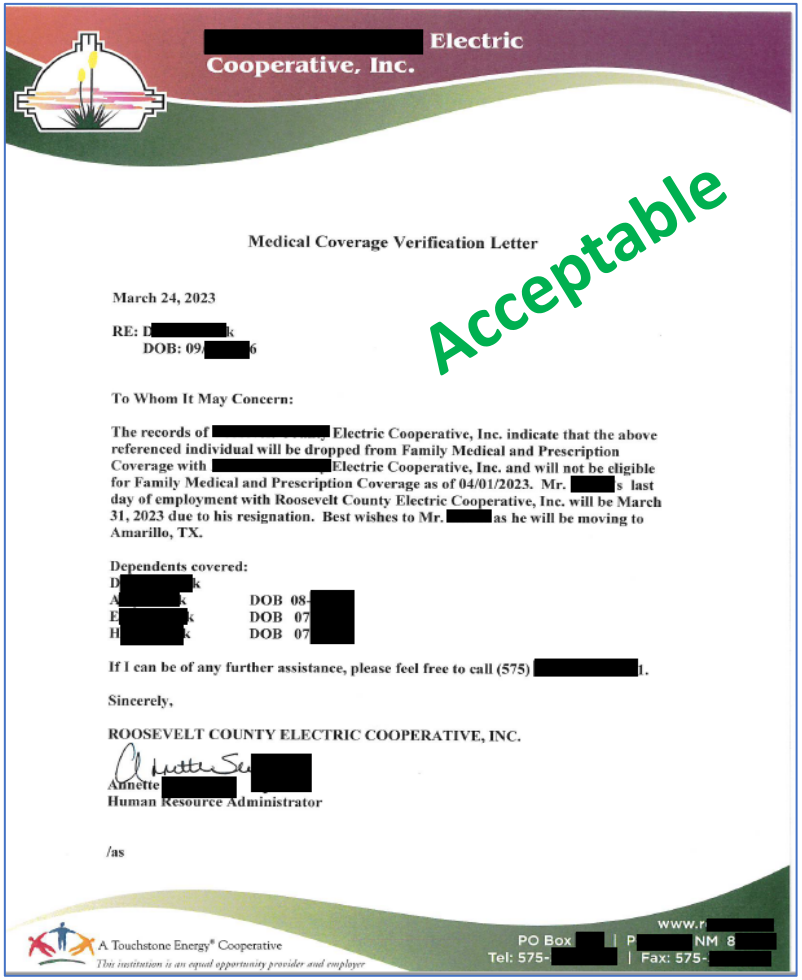
NMPSIA Benefits Enrollment

Supportive Documentation - Proof of Loss of Coverage



[redacted] Electric Cooperative, Inc.

Medical Coverage Verification Letter

Acceptable

March 24, 2023

RE: D[redacted]k
DOB: 09[redacted]6

To Whom It May Concern:

The records of [redacted] Electric Cooperative, Inc. indicate that the above referenced individual will be dropped from Family Medical and Prescription Coverage with [redacted] Electric Cooperative, Inc. and will not be eligible for Family Medical and Prescription Coverage as of 04/01/2023. Mr. [redacted]s last day of employment with Roosevelt County Electric Cooperative, Inc. will be March 31, 2023 due to his resignation. Best wishes to Mr. [redacted] as he will be moving to Amarillo, TX.

Dependents covered:
D[redacted]k
A[redacted]k DOB 08-[redacted]
B[redacted]k DOB 07[redacted]
H[redacted]k DOB 07[redacted]

If I can be of any further assistance, please feel free to call (575) [redacted]1.

Sincerely,

ROOSEVELT COUNTY ELECTRIC COOPERATIVE, INC.

Annette [redacted]
Human Resource Administrator

/as

A Touchstone Energy® Cooperative
This institution is an equal opportunity provider and employer

www.r[redacted]
PO Box [redacted] | P[redacted] NM 8[redacted]
Tel: 575-[redacted] | Fax: 575-[redacted]

Big Wave Industries

Big Wave Industries
555 Rincon Lane
Taos, NM, 87777
575-999-0001
BWI@hotmail.com
Bigwave.com

February 2, 2023

Loss of Coverage Notice

To NMPSIA Employer Group:

Who Lost the Coverage:	What Kind of Coverage was Lost:	Last Day of Coverage
Donald Duck	■ Medical ■ Dental ■ Vision	2/28/2023
Daisy Duck	■ Medical ■ Dental ■ Vision	2/28/2023
Huey Duck	■ Medical ■ Dental ■ Vision	2/28/2023
Dewey Duck	■ Medical ■ Dental ■ Vision	2/28/2023
Louie Duck	■ Medical ■ Dental ■ Vision	2/28/2023
	☐ Medical ☐ Dental ☐ Vision	

Why was the Coverage Lost:

■ Retirement ☐ Resignation ☐ Termination of Employment

☐ Reduction in Hours Worked ☐ Ineligible due to _____ (Divorce, Death, Age, etc.)

Respectfully,

Mickey Mouse

Mickey Mouse
HR Manager
Direct number: Cell 575-999-0021

Acceptable

New Mexico Public Schools Insurance Authority

EASI
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NMPSIA Benefits Enrollment

Timely Reporting by the Employer

6.50.10.12 **REPORTING REQUIREMENT:** Authority insurance providers depend on timely reporting of dismissals, resignations, change in status, reports of new employees and eligible dependents and those dropping coverages. The only source of this information is from the participating entity. Participating entities shall report this information on or before the 15th day following notification from the employee of the event. In the event they fail to so timely report, the responsible participating entity shall be liable for any losses an eligible employee or dependent may incur as a result of the failure to timely report.
[6.50.10.12 NMAC - N, 09/01/2014]

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

NMPSIA Benefits Enrollment

Timely Reporting by the Employee

Enroll within 31 days from Date of Hire or Qualifying Event

The Employee has 61 days to provide supportive documentation from the effective date or Qualifying Event date

- NMPSIA Monthly Topic Trainings +
- Online Benefit System Introductory Guide
- Accurate & Timely Reporting
- Leave of Absence Reporting
- Premium Billing & Bill Reconcilliation
- Employee Qualifying Events
- Timely Benefits Enrollment
- International Employee Benefits Enrollment
- How to Fill Out NMPSIA Forms Effectively
- Evidence of Insurability (EOI)
- Back to Basics
- Program Guide Knowledge

New Mexico Public Schools Insurance Authority

NMPSIA Benefits Enrollment

EASI
Erisa Administrative Services, Inc.

Late Reporting?

What Happens When You Are Late in Reporting a Change of Status?

NMPSIA requires timely reporting of enrollments, qualifying events, changes, and separation of employment along with any timely submission of required supportive documentation to your employer's benefits office. Not reporting timely may create consequences like:

- No retroactive effective or termination dates.
- Delayed effective dates.
- Delays or no access to benefit coverage.
- Waiting for the next open or switch enrollment for the following January 1st.
- Require satisfactory evidence of insurability for LTD or ADL coverage.
- Employer and/or NMPSIA will not refund premium.
- Not eligible for COBRA continuation.
- NMPSIA ineligible claim overpayments that are not eligible for collection by the insurance carrier, may be collected from the employee.

New Mexico Public Schools Insurance Authority

Consequences of Non-Compliance

Incomplete forms, using the wrong forms, no signatures or dates, no date stamp, unacceptable supportive documents, late reporting

- Who is harmed?
  - Employee
  - Employer
  - NMPSIA
  - EASI
  - All NMPSIA participating employers and employees

New Mexico Public Schools Insurance Authority

Consequences of Non-Compliance

Case Study: Actual Occurrence Example

- Employee submits resignation to end benefits 12/31/2019
  - No action taken by employer
- Employee calls in 2/2023 requesting to have benefits enrollment cancelled because employee is having issues with new employer benefits coverage

- Employee is retroactively terminated to 12/31/2019
  - No premium refund to the school or employee
  - Claims for medical and dental enrollment checked back to 1/1/2020 for a total of $10,758 in 2020

New Mexico Public Schools Insurance Authority

Consequences of Non-Compliance

Case Study: Actual Occurrence Example

- Impact to the school
  - Paid 38 months of two-party medical, dental and Basic Life premiums totaling: $53,358
  - May have to pay the $10,758 in claims costs

- School benefits eligible employees ≈ 1,750

- If one individual was missed, probability is that more employee resignations, terminations, retirements were missed
  - Premium impact to employer for ½% or 9 employees out of all eligible employees ≈ $466,878 (using this example above)
  - Premium impact to employer for 1% or 17 employees out of all eligible employees ≈ $933,757 (using this example above)

New Mexico Public Schools Insurance Authority

Consequences of Non-Compliance

Case Study: Actual Occurrence Example
What Can the Employer Do?

- Complete employee requests neatly, accurately, completely and timely
- Respond to Erisa representative requests immediately
- Review and respond to Confirmation Notices immediately
- Identify errors with enrollment and payroll
- Review any electronic enrollment records on the Online System
  - Don't approve if they don't meet the rules of enrollment
- Reconcile monthly NMPSIA bills to monthly premium deductions
- Track transactions for next month's bill

New Mexico Public Schools Insurance Authority

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	Patrick.Sandoval@psia.nm.gov
NMPSIA	Martha Quintana	Deputy Director	Martha.Quintana@psia.nm.gov
NMPSIA	Cyndi Archuleta	Benefits and Wellness Manager	Cyndi.Archuleta@psia.nm.gov
NMPSIA	Kaylei Jones	Benefits and Wellness Program Coordinator	Kaylei.Jones@psia.nm.gov
EASI	Kathy Payanes	Account Manager	K.Payanes@easitpa.com