

# Accurate & Timely Reporting

TRAINING



# Accurate & Timely Reporting - Objectives

By the end of this training, you will be able to:

- Report Enrollment and Qualifying Events Accurately and Timely
- Understand the Enrollment and Change Process
- Identify Different Types of Employees
- Understand Employer's Responsibility
- Recognize Available Resources for Accurate and Timely Reporting

# Timely Reporting

## NMPSIA Rule 6.50.10.12 NMAC

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]

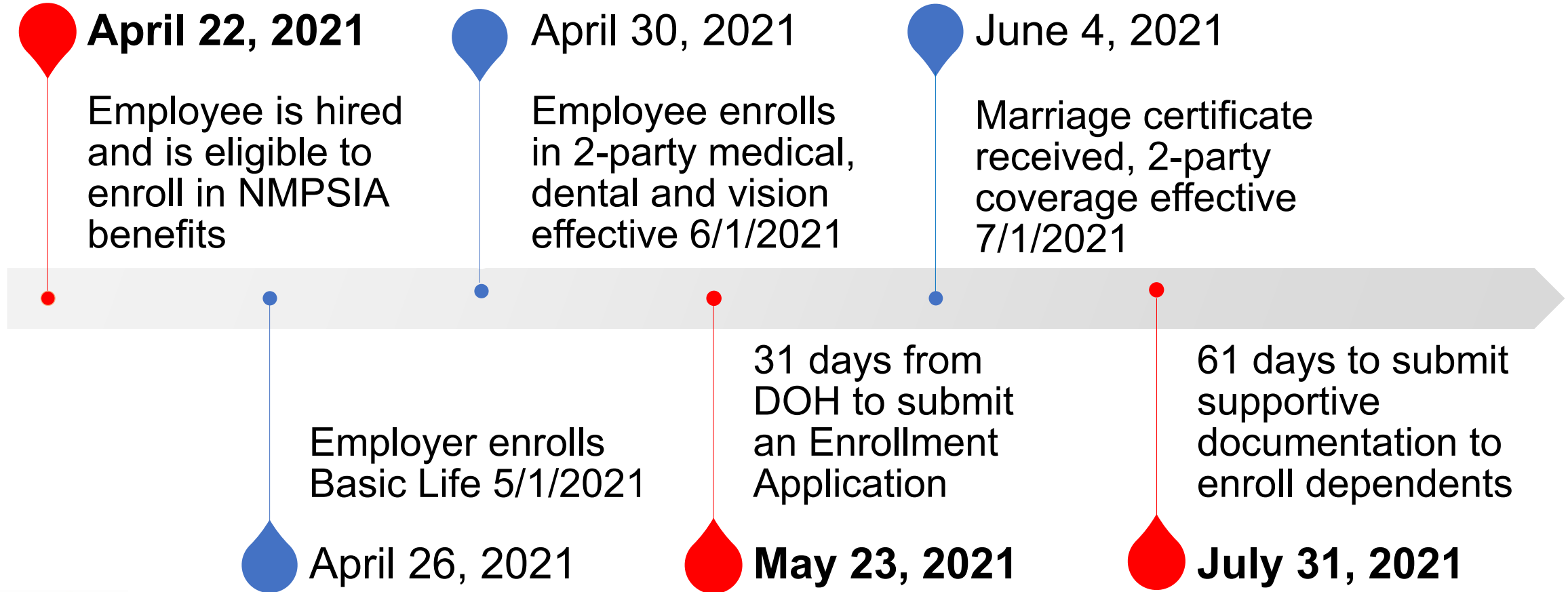
# Accurate and Timely Reporting

- Enroll within 31 days of Date of Hire (DOH) or Qualifying Event (QE)
- 61 days to provide supportive documentation from the effective date or QE date



# Timeline to Report a New Hire Enrollment

For example:



# Employer New Hire Timely Reporting Process

## Steps to follow

Step 1: Notified of a newly hired employee (EE)

Step 2: Collect the DOH, hours worked per week and base annual earnings

Step 3: Confirm the EE is benefits eligible

- New Hire (NH) works more than 15 hours per week
  - Enroll eligible EE in Basic Life
- NH works more than 20 hours per week
  - Advise the EE of the enrollment timeline - 31 days from DOH
  - Meet with EE to offer NMPSIA benefits
  - Decide on an effective date
  - Request **EMPLOYEE ENROLLMENT APPLICATION** and any required supportive documents

# Employer New Hire Timely Reporting Process

## Steps to follow (continued)

### Step 4: Receive **EMPLOYEE ENROLLMENT APPLICATION**

- Date stamp all forms and documents with a “Received Date”
- Review the form is completed in its entirety, signed and dated by the employee
- Review any supportive documents provided
- Complete the Basic Life and other coverage effective date
- Provide District/Entity Name and number
- Complete section 6 **EMPLOYER CERTIFICATION** with DOH, base annual salary, # of hours worked weekly, job title, sign and date

# Employer New Hire Timely Reporting Process

## Steps to follow (continued)

Step 5: Send to Erisa Benefits Representative through the NMPSIA Benefits Online System (Online) electronically or securely through the Feedback link

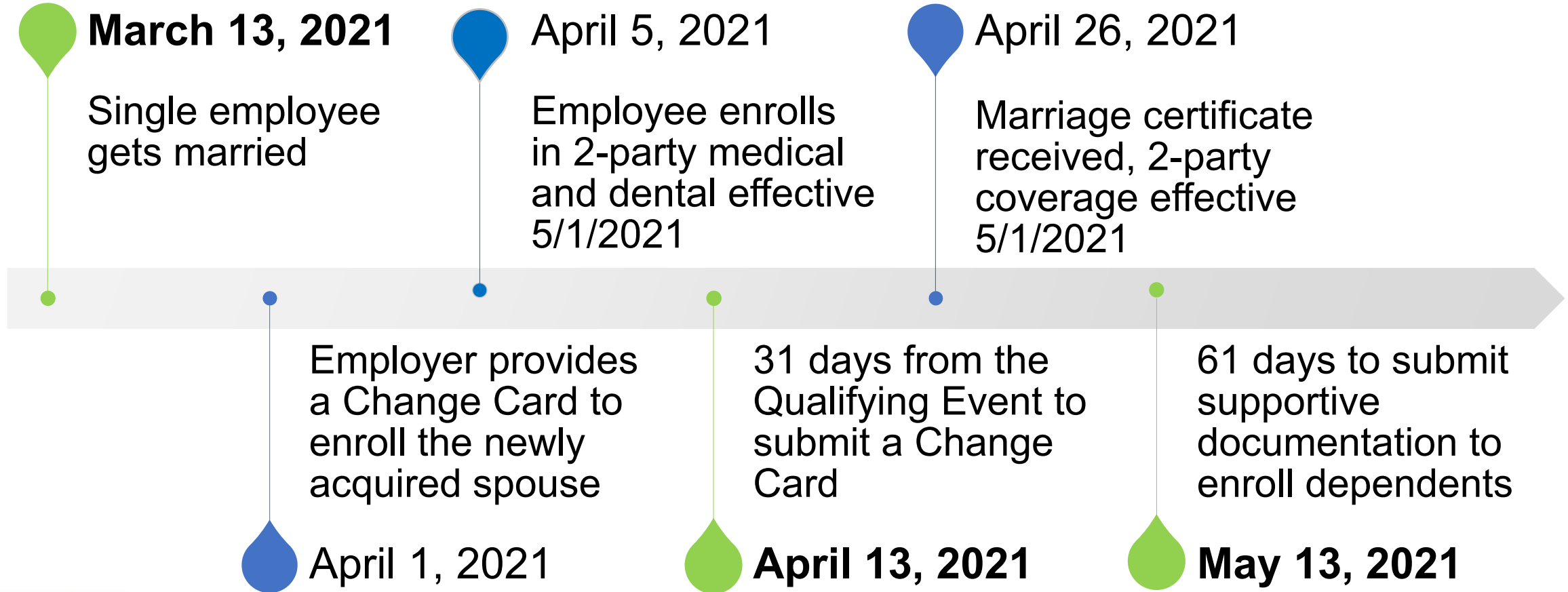
Step 6: Confirm Erisa honored the EE request

- Check Online Inquiry or Confirmation of Enrollment
  - Confirm the effective dates were honored
- Check Online Premium tab in Inquiry record
  - Validate premiums for payroll deductions
- Report any discrepancies to Erisa immediately



# Timeline to Report a Qualifying Event

For example:



# Employer QE Timely Reporting Process

## Steps to follow

Step 1: EE notifies employer (ER) of a change in status

Step 2: Remind the EE of the enrollment timeline - 31 days from the QE

- Advise EE to complete an **EMPLOYEE CHANGE CARD** and provide any required supportive documentation

Step 3: Receive **EMPLOYEE CHANGE CARD**

- Date stamp all forms and documents with a “Received Date”
- Review the form is completed in its entirety, signed and dated by the employee
- Review any supportive documents provided
- Complete the effective date of the change
- Provide District/Entity Name and number
- Complete section 6 **EMPLOYER CERTIFICATION** with a signature and date

# Employer QE Timely Reporting Process

## Steps to follow

Step 4: Send to Erisa Benefits Representative through the NMPSIA Benefits Online System (Online) electronically or securely through the Feedback link

Step 5: Confirm Erisa honored the EE request

- Check Online Inquiry or Confirmation of Enrollment
  - Confirm the effective dates were honored
- Check Online Premium tab in Inquiry record
  - Validate premiums for payroll deductions
- Report any discrepancies to Erisa immediately

# Reporting Enrollment or Changes to Erisa

## NMPSIA Online Benefits System Employer Login

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



The screenshot shows the login interface for the New Mexico Public Schools Insurance Authority. At the top left is the organization's logo, a stylized sun with rays. To its right, the text "New Mexico Public Schools Insurance Authority" is displayed in white on a dark blue background. Below this is a light purple banner with the text "Sign In...". Underneath the banner are three login buttons: "Employee Login" with the subtext "You are an Employee.", "Employer Login" with the subtext "You are an Employer.", and "Manager Login" with the subtext "You are a Manager." Each button has a colored underline: blue for Employee, purple for Employer, and green for Manager.



# Reporting Enrollment or Changes to Erisa NMPSIA Online Benefits System “Online”



The screenshot displays the user interface for the New Mexico Public Schools Insurance Authority's online benefits system. At the top, a dark blue header contains the organization's logo and name. Below this is a horizontal navigation bar with buttons for Home, Inquiry, Review, New Hire, Employer Information, Cancel EE, Report LOA, Training Material, Feedback, and Logout. Two dropdown menus are open: one under 'Review' and one under 'New Hire'. The 'Review' dropdown lists: Basic Info, New Hire, Change Enrollment, Change Beneficiary, Cancel EE, Premium Split, Review Batch New Hire, and Change Salary. The 'New Hire' dropdown lists: Single New Hire and Batch New Hire. Additionally, two buttons, 'Cancel EE' and 'Report LOA', are highlighted with black boxes.

# NMPSIA Employee Enrollment Application

[https://nmpsia.com/pdfs/1.1.2021\\_Enrollment\\_Application\\_2020-09-10.pdf](https://nmpsia.com/pdfs/1.1.2021_Enrollment_Application_2020-09-10.pdf)

District Name and District Number

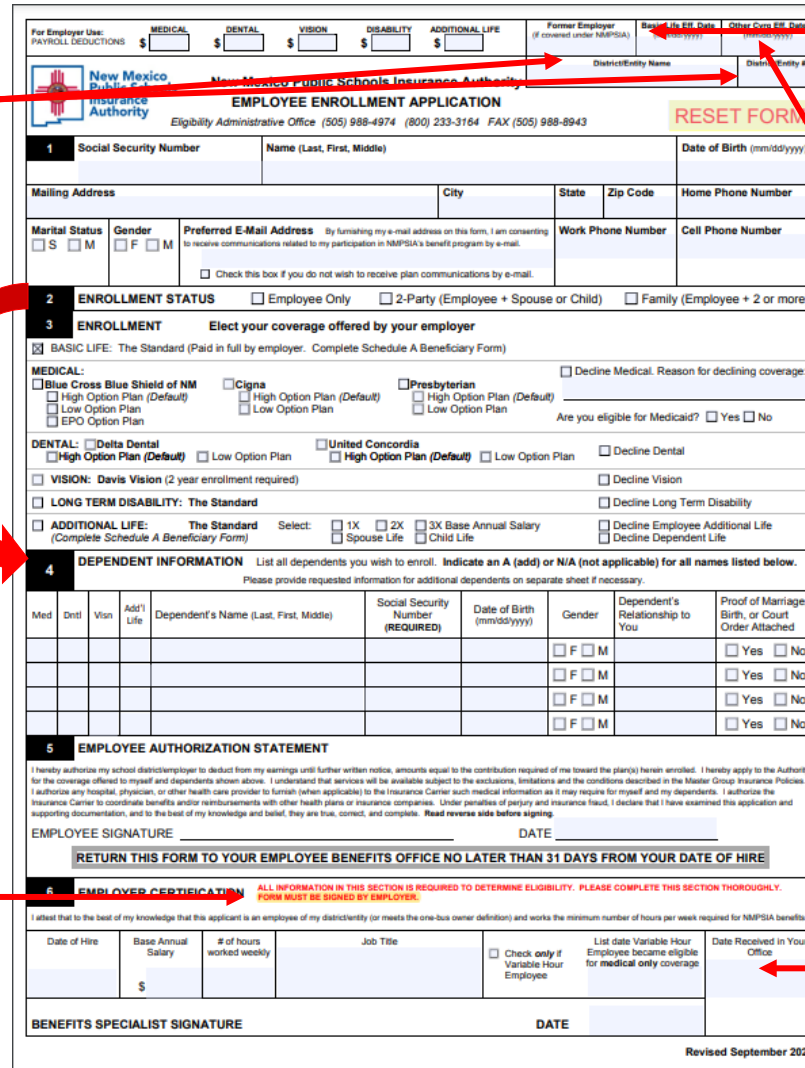
Section 4 Dependent Information reflects selection of Section 2 Enrollment Status & 3 Enrollment

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

Basic Life is always effective 1<sup>st</sup> of the month following the employee's date of hire

No retroactive effective dates allowed

Date Stamp Upon receipt



**For Employer Use:** MEDICAL \$ DENTAL \$ VISION \$ DISABILITY \$ ADDITIONAL LIFE \$

Former Employer (if covered under NMPSIA) Basic Life Eff. Date Other Core Eff. Date

District/Entity Name District/Entity #

**EMPLOYEE ENROLLMENT APPLICATION**

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

**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

**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  Cigna  Presbyterian  Decline Medical. Reason for declining coverage:

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

Low Option Plan  Low Option Plan  Low Option Plan Are you eligible for Medicaid?  Yes  No

DENTAL:  Delta Dental  United Concordia

High Option Plan (Default)  Low Option Plan  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 Select:  1X  2X  3X Base Annual Salary  Decline Employee Additional Life

Complete Schedule A Beneficiary Form  Spouse Life  Child 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	Adst/ 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
							<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

**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 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
	\$			<input type="checkbox"/>		

BENEFITS SPECIALIST SIGNATURE DATE

Revised September 2020

# NMPSIA Employee Change Card

[https://nmpsia.com/pdfs/1.1.2021\\_Change\\_Card\\_2020-09-13.pdf](https://nmpsia.com/pdfs/1.1.2021_Change_Card_2020-09-13.pdf)

District Name and District Number

Section 3 Dependent Information reflects selection of 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

Other coverage effective date

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

Date stamp upon receipt

For Employer Use: MEDICAL DEDUCTIONS \$		DENTAL \$	VISION \$	DISABILITY \$	ADDITIONAL LIFE \$	Former Employer (if covered under NMPSIA)	Basic Life Eff. Date (mm/dd/yyyy)	Other Cvg Eff. Date (mm/dd/yyyy)	
 <b>New Mexico Public Schools Insurance Authority</b> <b>EMPLOYEE CHANGE CARD</b> Eligibility Administration Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943						District/Entity Name		District/Entity #	
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			
<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> F <input type="checkbox"/> M	By furnishing my e-mail address on this form, I am consenting to receive communications related to my participation in NMPSIA's benefit program by e-mail.							
REASON FOR CHANGE:			Answer questions below						
<input type="checkbox"/> Late Enrollment			<input type="checkbox"/> New address and/or phone number			What event took place?			
<input type="checkbox"/> Open/Switch Enrollment			<input type="checkbox"/> Qualifying Event			What date did event take place?			
<b>2 ENROLLMENT</b>									
What is your current enrollment status?			<input type="checkbox"/> Employee Only			<input type="checkbox"/> 2-Party (Employee + Spouse or Child)			
What enrollment status are you requesting?			<input type="checkbox"/> Employee Only			<input type="checkbox"/> 2-Party (Employee + Spouse or Child)			
Check One:			<input checked="" type="checkbox"/> ADD COVERAGE			<input type="checkbox"/> CANCEL COVERAGE			
			<input type="checkbox"/> SWITCH ENROLLMENT						
<input checked="" type="checkbox"/> BASIC LIFE: The Standard									
<b>MEDICAL:</b>									
<input type="checkbox"/> Blue Cross Blue Shield of NM			<input type="checkbox"/> Cigna			<input type="checkbox"/> Presbyterian			
<input type="checkbox"/> High Option (Default)			<input type="checkbox"/> High Option Plan (Default)			<input type="checkbox"/> High Option (Default)			
<input type="checkbox"/> Low Option			<input type="checkbox"/> Low Option Plan			<input type="checkbox"/> Low Option			
<input type="checkbox"/> EPO Option						Reason: _____			
Eligible for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<b>DENTAL:</b> Delta Dental: <input type="checkbox"/> High Option (Default) <input type="checkbox"/> Low Option <input type="checkbox"/> Decline Dental									
<input type="checkbox"/> VISION: Davis Vision (2 year enrollment required) <input type="checkbox"/> Decline Vision									
<input type="checkbox"/> LONG TERM DISABILITY: The Standard (Qualifying Event or Evidence of Insurability) <input type="checkbox"/> Decline Long Term Disability									
<input type="checkbox"/> ADDITIONAL LIFE: The Standard Select: <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X Base Annual Salary <input type="checkbox"/> Spouse Life <input type="checkbox"/> Child Life <input type="checkbox"/> Decline Employee Additional Life <input type="checkbox"/> Decline Dependent Life									
<b>3 DEPENDENT INFORMATION</b> 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	Vsion	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
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4 EMPLOYEE AUTHORIZATION STATEMENT</b>									
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. <b>Read reverse side before signing.</b>									
EMPLOYEE SIGNATURE _____					DATE _____				
<b>RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR QUALIFYING EVENT</b>									
<b>5 EMPLOYER CERTIFICATION</b> 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	<input type="checkbox"/> 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: _____				

# NMPSIA Employee Enrollment Application

## Recognize errors

Section 4 **DEPENDENT INFORMATION** reflects selection in section 2 **ENROLLMENT STATUS** and section 3 **ENROLLMENT**


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

Basic Life is always effective 1<sup>st</sup> of the month following the employee's date of hire

Effective date within 60 days from date of hire

Employer Name and Employer Number

Date stamp upon receipt

For Employer Use: PAYROLL DEDUCTIONS \$		MEDICAL \$	DENTAL \$	VISION \$	DISABILITY \$	ADDITIONAL LIFE \$	Former Employer (if covered under NMPSIA)	Basic Life Eff. Date (mm/dd/yyyy) 05/01/2021	Other Cvg Eff. Date (mm/dd/yyyy) 06/01/2022
 <b>New Mexico Public Schools Insurance Authority</b> Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943							District/Entity Name <b>Belen Consolidated</b>		District/Entity No. <b>87</b>
<b>1 Social Security Number</b> 123-45-6789		<b>Name (Last, First, Middle)</b> Coyote, Wile E.				<b>Date of Birth (mm/dd/yyyy)</b> 01/01/1989			
<b>Mailing Address</b> 123 Acme Street			<b>City</b> Belen	<b>State</b> NM	<b>Zip Code</b> 87002	<b>Home Phone Number</b> 505-123-4567		<b>Cell Phone Number</b> 505-123-4567	
<b>Marital Status</b> <input type="checkbox"/> S <input checked="" type="checkbox"/> M		<b>Gender</b> <input type="checkbox"/> F <input checked="" type="checkbox"/> M		<b>Preferred E-Mail Address</b> wile@gmail.com			<b>Work Phone Number</b> 505-234-5678		<b>Cell Phone Number</b> 505-123-4567
<b>2 ENROLLMENT STATUS</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> 2-Party (Employee + Spouse or Child) <input checked="" type="checkbox"/> Family (Employee + 2 or more)		<b>3 ENROLLMENT</b> Elect your coverage offered by your employer							
<input checked="" type="checkbox"/> <b>BASIC LIFE: The Standard</b> (Paid in full by employer. Complete Schedule A Beneficiary Form)									
<b>MEDICAL:</b> <input type="checkbox"/> Blue Cross Blue Shield of NM <input checked="" type="checkbox"/> Cigna <input type="checkbox"/> Presbyterian <input type="checkbox"/> Decline Medical. Reason for declining coverage: <input type="checkbox"/> High Option Plan (Default) <input checked="" type="checkbox"/> High Option Plan (Default) <input type="checkbox"/> High Option Plan (Default) <input type="checkbox"/> Low Option Plan <input type="checkbox"/> Low Option Plan <input type="checkbox"/> Low Option Plan <input type="checkbox"/> EPO Option Plan Are you eligible for Medicaid? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
<b>DENTAL:</b> <input checked="" type="checkbox"/> Delta Dental <input type="checkbox"/> United Concordia <input type="checkbox"/> Decline Dental <input checked="" type="checkbox"/> High Option Plan (Default) <input type="checkbox"/> Low Option Plan <input type="checkbox"/> High Option Plan (Default) <input type="checkbox"/> Low Option Plan									
<input checked="" type="checkbox"/> <b>VISION: Davis Vision</b> (2 year enrollment required) <input type="checkbox"/> Decline Vision									
<input checked="" type="checkbox"/> <b>LONG TERM DISABILITY: The Standard</b> <input type="checkbox"/> Decline Long Term Disability									
<input type="checkbox"/> <b>ADDITIONAL LIFE: The Standard</b> (Complete Schedule A Beneficiary Form) Select: <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X Base Annual Salary <input type="checkbox"/> Decline Employee Additional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Child Life <input type="checkbox"/> Decline Dependent Life									
<b>4 DEPENDENT INFORMATION</b> 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
x	x	x	x	Coyote, Lilly	987-65-4321	02/01/1989	<input checked="" type="checkbox"/> F <input type="checkbox"/> M	spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
x	x	x	x	Coyote, Little	876-54-3210	01/01/2021	<input type="checkbox"/> F <input checked="" type="checkbox"/> M	son	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5 EMPLOYER AUTHORIZATION STATEMENT</b>									
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 <u>Wile E. Coyote</u>						DATE <u>04/12/2021</u>			
<b>RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR DATE OF HIRE</b>									
<b>6 EMPLOYER CERTIFICATION</b> 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	<input type="checkbox"/> Check only if Variable Hour Employee		List date Variable Hour Employee became eligible for medical only coverage	Date Received in Your Office		
04/12/2021	\$ 35,000.00	40.00	Administrative Assistant				APR 12 2021		
<b>BENEFITS SPECIALIST SIGNATURE</b> <u>[Signature]</u>				DATE		04/12/2021			



## Benefits Eligible Employee

**Regular** Employee or **Variable Hour** Employee

The employer is responsible for identifying **regular** employees and **variable hour** employees through the employer's local policies



## Regular Employee

Legally contracted, full-time employee\* (FTE) eligible to participate in the NMPSIA Employees Benefits Program. Based on the NMPSIA Rules and Regulations employees qualify if they meet the following:

- Basic Life: Work a minimum of 15 hours per week –Employers are required to enroll regular employees to Basic Life coverage if they work a minimum of 15 hours per week or more
- All Other Lines of Coverage: Work a minimum of 20 hours per week
- Part-time resolution (PTR) approved by the NMPSIA Board allows employer to offer full benefits to employees working less than 20 hours per week, but at least 15 hours per week. A part-time resolution has nothing to do with Basic Life insurance enrollment.

\*Meets actively at work requirement and works minimum number of hours per week required for benefits enrollment

## Variable Hour Employee

A **variable hour employee** is defined as an employee not on contract and one or more of the following apply:

- Job classification is substitute teacher or substitute employee
- Non-contracted employee (a sub voucher or timesheet is used)
- Hired to serve in a non-benefit eligible position
- No guaranteed set work hours or fluctuating hours
- No fixed working pattern
- Work is limited to a certain period of time
- Work is seasonal or temporary
- On call or as needed

## Variable Hour Employee (continued)

The **employer** determines which employees meet the variable hour definition and when the employee becomes eligible to be offered medical coverage only

The **employer** needs to identify these variable hour employees properly when using the NMPSIA Online Benefits System or when completing the Employer Certification section of the Employee Enrollment Application or Employee Change Card, this includes the “date eligible for benefits” section

## Variable Hour Employee (continued)

If the employer has determined a long-term substitute or permanent substitute job title meets the employer's definition of a benefit's eligible employee, **the job title reported on enrollment forms or claim forms should not include the job title as "substitute"**

# Recognize Accurate & Timely Reporting Resources

## NMPSIA Accurate & Timely Reporting Toolbox

- Employer's Local Policies
- NMPSIA Website and Program Guide
- Glossary of Acronyms
- Process Steps for Employer Timely Reporting
- How to Accurately and Timely Report Video
- Employee Enrollment Application and Change Card
- Frequently Asked Questions (FAQ)
- Erisa Staff Resources



# Recognize Accurate & Timely Reporting Resources

## Employer's Local Benefits Enrollment Policies



## Recognize Accurate & Timely Reporting Resources

NMPSIA Website and  
Program Guide (pages 7-13)

Visit <https://nmpsia.com/>



New Mexico  
Public Schools  
Insurance  
Authority



NMPSIA  
*Wellness*

## EMPLOYEE HEALTH & WELL-BEING BENEFITS PROGRAM GUIDE

July 2022



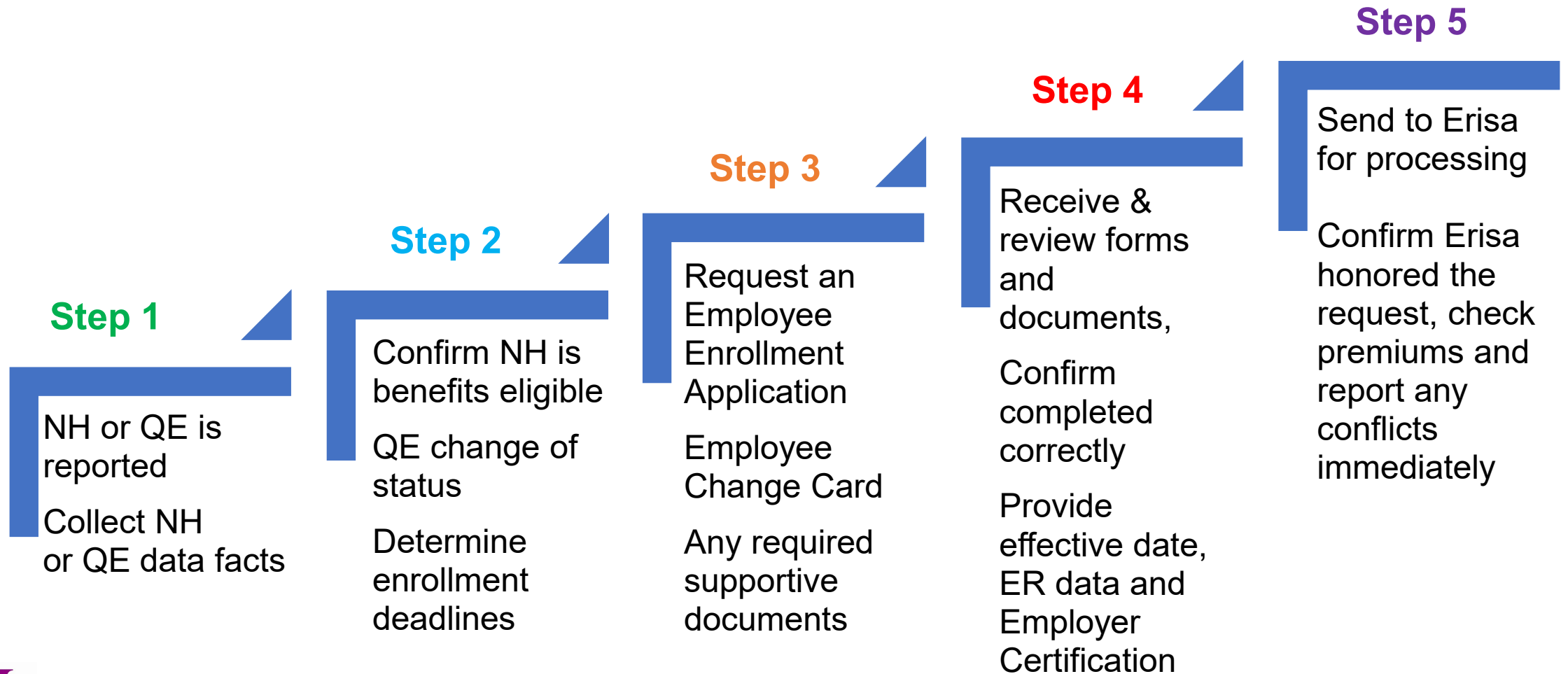
# Recognize Accurate & Timely Reporting Resources

## Glossary of Acronyms

Accurate and Timely Reporting Glossary of Acronyms		
Acronym	Term	Definition
DOH	Date of Hire	The first day a new employee reports to work.
EASI or Erisa	Erisa Administrative Services, Inc.	NMPSIA's Third Party Administrator who handles enrollment, eligibility, premium billing, premium collection and COBRA administration.
EE	Employee	A benefits eligible person employed by a NMPSIA participating employer.
ER	Employer	NMPSIA participating employer.
FAQ	Frequently Asked Questions	A list of questions and answers relating to a particular subject, especially one giving basic information for users of a website.
FTE	Full Time Employee	An employee who meets the actively at work requirement and works the minimum number of hours per week required for benefits enrollment.
NH	New Hire	A newly hired benefits eligible employee who works for a NMPSIA participating employer.
NMPSIA	New Mexico Public Schools Insurance Authority	Serves as the purchasing agency for public school districts, post-secondary educational entities, charter schools and other educational entities. Through NMPSIA, member participating employers are afforded the opportunity to offer quality employee benefit and risk coverages.
Online	NMPSIA Online Benefits System	NMPSIA's electronic enrollment system available to participating employers and benefits enrolled employees that allows users to view, update and change enrollment.
PTR	Part Time Resolution	Allows employers to offer full benefits to employees who work less than 20 hours per week but at least 15 hours per week through an annual employer resolution approved by the NMPSIA board.
QE	Qualifying Event	A change or life event that requires an employee to report and update benefit enrollment or status as defined by NMPSIA Rules and Regulations.
Regular	Regular Employee	Legally contracted, full-time employee eligible to participate in the NMPSIA Employees Benefits Program.
VHEE	Variable Hour Employee	A <b>variable hour employee</b> is defined as an employee not on contract and one or more of the following apply: Job classification is substitute teacher or substitute employee, non-contracted employee (a sub voucher or timesheet is used), hired to serve in a non-benefit eligible position, no guaranteed set work hours, fluctuating hours, no fixed working pattern, work is limited to a certain period of time, work is seasonal or temporary, on call or as needed

# Recognize Accurate & Timely Reporting Resources

## Enrollment Process – Follow the steps



# Recognize Accurate & Timely Reporting Resources

## How to Accurately and Timely Report Video

[https://nmopsia.com/movies/Timely\\_Reporting\\_Enrollments.mp4](https://nmopsia.com/movies/Timely_Reporting_Enrollments.mp4)

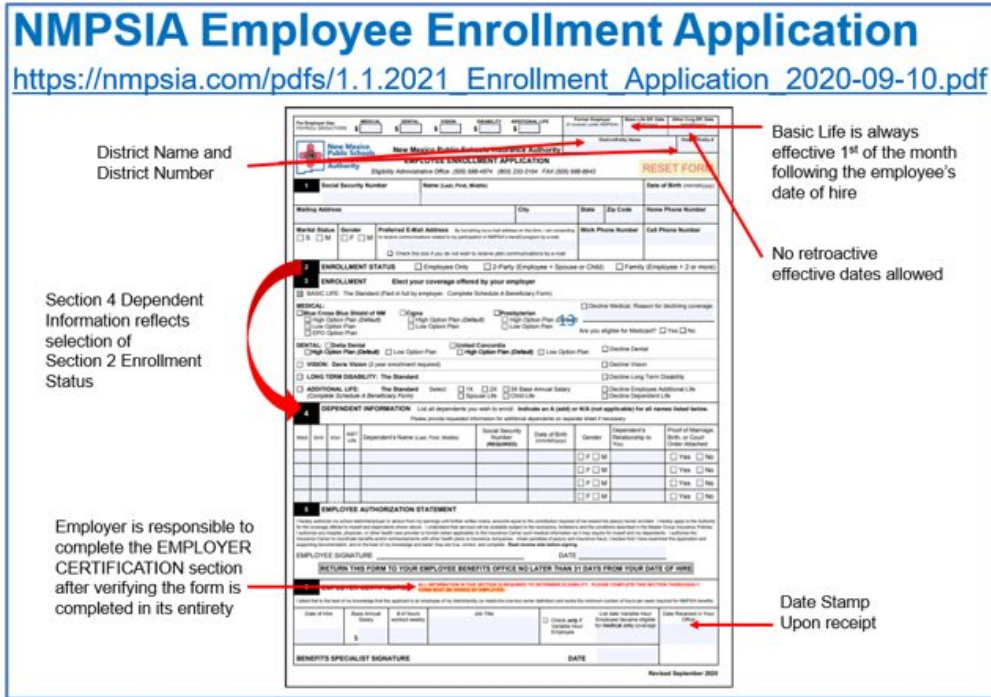


# Recognize Accurate & Timely Reporting Resources

## Employee Enrollment Application and Change Card

### NMPSIA Employee Enrollment Application

[https://nmipsia.com/pdfs/1.1.2021\\_Enrollment\\_Application\\_2020-09-10.pdf](https://nmipsia.com/pdfs/1.1.2021_Enrollment_Application_2020-09-10.pdf)



**District Name and District Number** (points to District Name and District Number field)

**Basic Life is always effective 1<sup>st</sup> of the month following the employee's date of hire** (points to Basic Life section)

**No retroactive effective dates allowed** (points to Enrollment Start Date field)

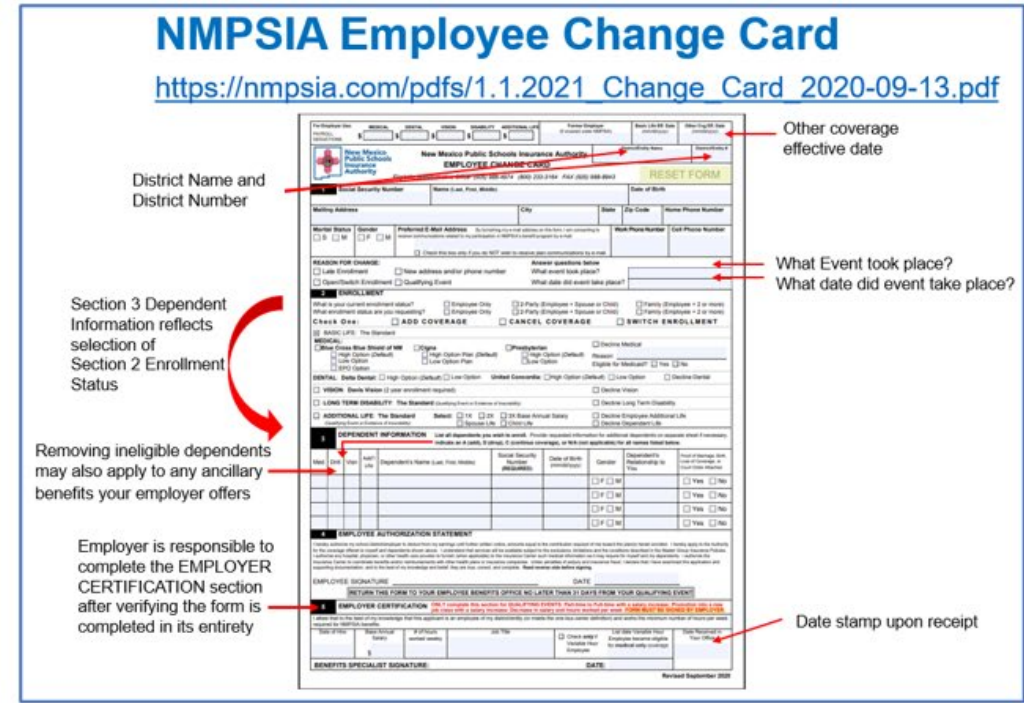
**Section 4 Dependent Information reflects selection of Section 2 Enrollment Status** (points to Dependent Information section)

**Employer is responsible to complete the EMPLOYER CERTIFICATION section after verifying the form is completed in its entirety** (points to Employer Certification section)

**Date Stamp Upon receipt** (points to Date field)

### NMPSIA Employee Change Card

[https://nmipsia.com/pdfs/1.1.2021\\_Change\\_Card\\_2020-09-13.pdf](https://nmipsia.com/pdfs/1.1.2021_Change_Card_2020-09-13.pdf)



**District Name and District Number** (points to District Name and District Number field)

**Other coverage effective date** (points to Other Coverage Effective Date field)

**What Event took place? What date did event take place?** (points to Reason for Change section)

**Section 3 Dependent Information reflects selection of Section 2 Enrollment Status** (points to Dependent Information section)

**Removing ineligible dependents may also apply to any ancillary benefits your employer offers** (points to Dependent Information section)

**Employer is responsible to complete the EMPLOYER CERTIFICATION section after verifying the form is completed in its entirety** (points to Employer Certification section)

**Date stamp upon receipt** (points to Date field)

# Recognize Accurate & Timely Reporting Resources

## Frequently Asked Questions (FAQ)



### Accurate and Timely Reporting Employer Frequently Asked Questions

- 1. How many days does a new employee have to enroll in benefits?**  
A new hire employee has 31 days from their date of hire to enroll in benefits.
- 2. When does Basic Life coverage become effective?**  
The first of the following month from the date of hire.
- 3. How many days does an employee have to report a Qualifying Event?**  
MUST report within 31 days of the Qualifying Event.
- 4. How many days does an employee have to submit documentation to enroll dependents?**  
61 Days from the date coverage is to start.
- 5. What effective date does other lines of coverage begin for a new employee whose date of hire is 4/15/2021?**  
The employee can select to add coverage beginning either 5/1, 6/1 or 7/1 as long as they are enrolling within 31 days of their date of hire
- 6. Is a part-time employee who works 16 hours per week eligible for Basic Life benefits?**  
Yes. An employee working 15 hours minimum per week is eligible for the Basic Life benefit.
- 7. A new employee forgot to sign the Enrollment Application can I submit to Erisa without the signature?**  
No. Erisa will not accept an Enrollment application or Change card without the employee or employer's signatures.
- 8. How can I check to make sure that a Change card which I submitted via the NMPSIA Online Benefits system was processed by Erisa?**  
Check online inquiry or Confirmation of Enrollment on the Online Benefits System.
- 9. Is a divorce a qualifying event?**  
Yes. Employee MUST report within 31 days of the final divorce date and MUST submit a copy of the final divorce decree as supportive documentation.
- 10. Can NMPSIA determine whether an employee is a Regular or Variable Hour employee?**  
No. The employer is responsible for identifying regular and variable hour employees through their local policies.
- 11. Can other lines of coverage begin on the first day of the current month the employee enrolls?**  
No retroactive dates are allowed.
- 12. Where on the Enrollment Application or Change card do I date stamp "Received"?**  
On the lower right-hand corner of both the Enrollment application and Change card.

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ANY  
QUESTIONS?



**Find resources in the  
Accurate and Timely Reporting  
Toolbox at [nmpsia.com](http://nmpsia.com)**