New Mexico Public Schools Insurance Authority

Training Objectives

By the end of this session, you should be able to:

- Understand the importance of filling out NMPSIA forms neatly, accurately and completely
- Understand the significance of correct information on forms
- Locate desired NMPSIA forms
- Identify required data for completion of each NMPSIA form
- Recognize available resources

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New Mexico Public Schools Insurance Authority

Completing NMPSIA Forms

Why is it Important?

What is the impact on ALL parties involved when NMPSIA forms are completed and submitted incorrectly?

- Employee
- Employer
- NMPSIA
- Erisa

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New Mexico Public Schools Insurance Authority

The importance of filling out NMPSIA forms neatly, accurately, and completely

- NMPSIA forms are official documents because they are proof that information has been provided.
- Each form is completed for a particular purpose. Different forms require different kinds of information. Forms are used for gathering information, registration, identification and certification.
- NMPSIA forms require information such as name, address, date of birth and so on.
- This information must all be provided in a complete and accurate way, otherwise, you may provide wrong or incomplete information making you ineligible for a specific benefit.

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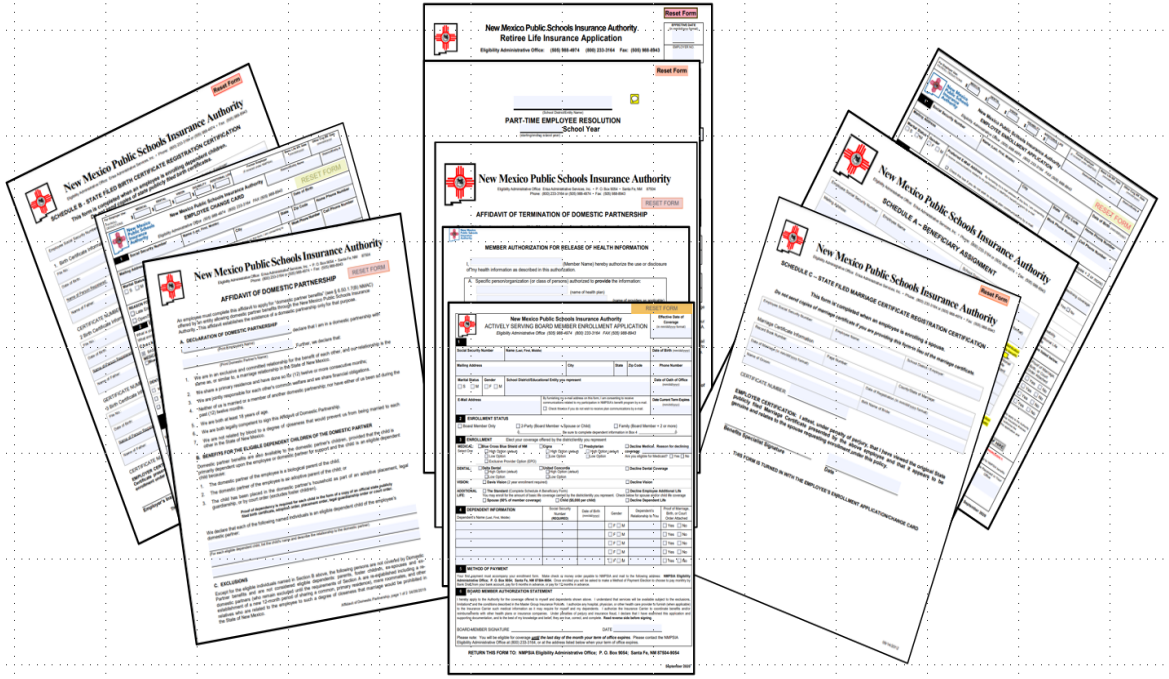
New Mexico Public Schools Insurance Authority

Completing NMPSIA Forms

https://nmpsia.com/Employers.html

Insurance Forms

- Employee Enrollment Application
- Schedule A - for Beneficiary Designation
- Schedule B - for Birth Registration
- Schedule C - for Marriage Registration
- 2021 Change Card
- Affidavit for Domestic Partner
- Termination of Domestic Partner
- Retiree Life Insurance Application
- Board Member Application
- Release of Health Information
- Sample Loss of Coverage Form
- Part-Time Resolution Template



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Employee Enrollment Application

https://nmpsia.com/pdfs/1.1.2021_Enrollment_Application_2020-09-10.pdf

District Name and District Number

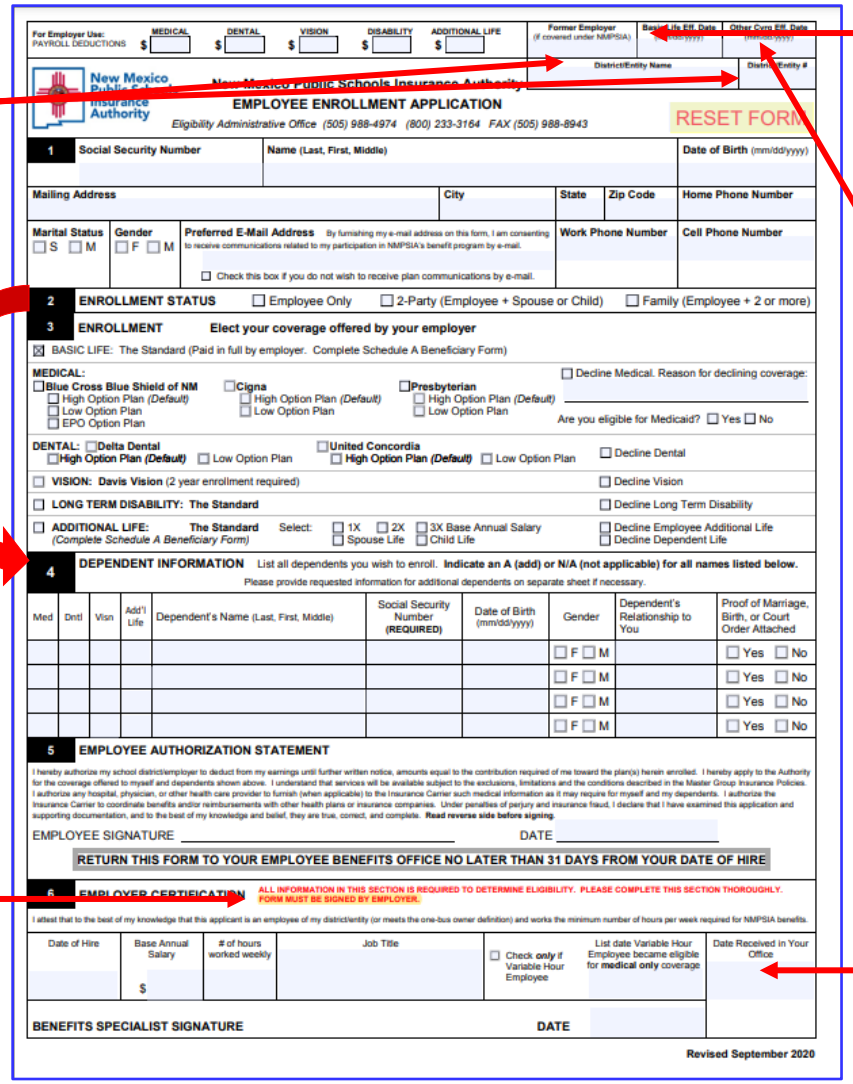
Section 4 Dependent Information reflects selection of **Section 2** Enrollment Status

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

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

No retroactive effective dates allowed

Date Stamp Upon receipt



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: ☐ Decline Medical. Reason for declining coverage:

☐ 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

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
							☐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) 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
	$					

BENEFITS SPECIALIST SIGNATURE DATE

Revised September 2020

New Mexico Public Schools Insurance Authority

Employee Change Card

https://nmpsia.com/pdfs/1.1.2021_Change_Card_2020-09-13.pdf

District Name and District Number

Other coverage effective date

What Event took place?

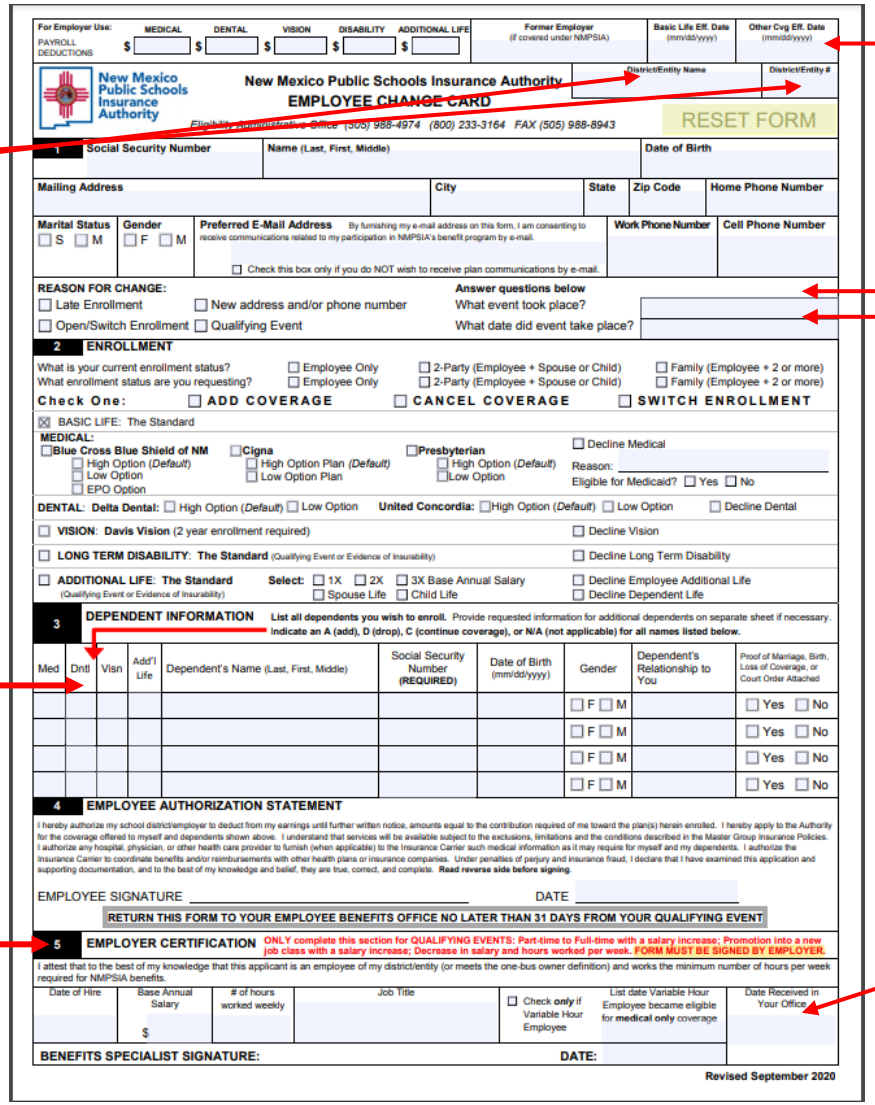
What date did event take place?

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

Date stamp upon receipt



New Mexico Public Schools Insurance Authority
EMPLOYEE CHANGE CARD
Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943
RESET 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 Cvg Eff. Date (mm/dd/yyyy)
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 ☐ S ☐ M | Gender ☐ F ☐ M | Preferred E-Mail Address — 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. | Work Phone Number | Cell Phone Number
☐ Check this box only if you do NOT wish to receive plan communications by e-mail.

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 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 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

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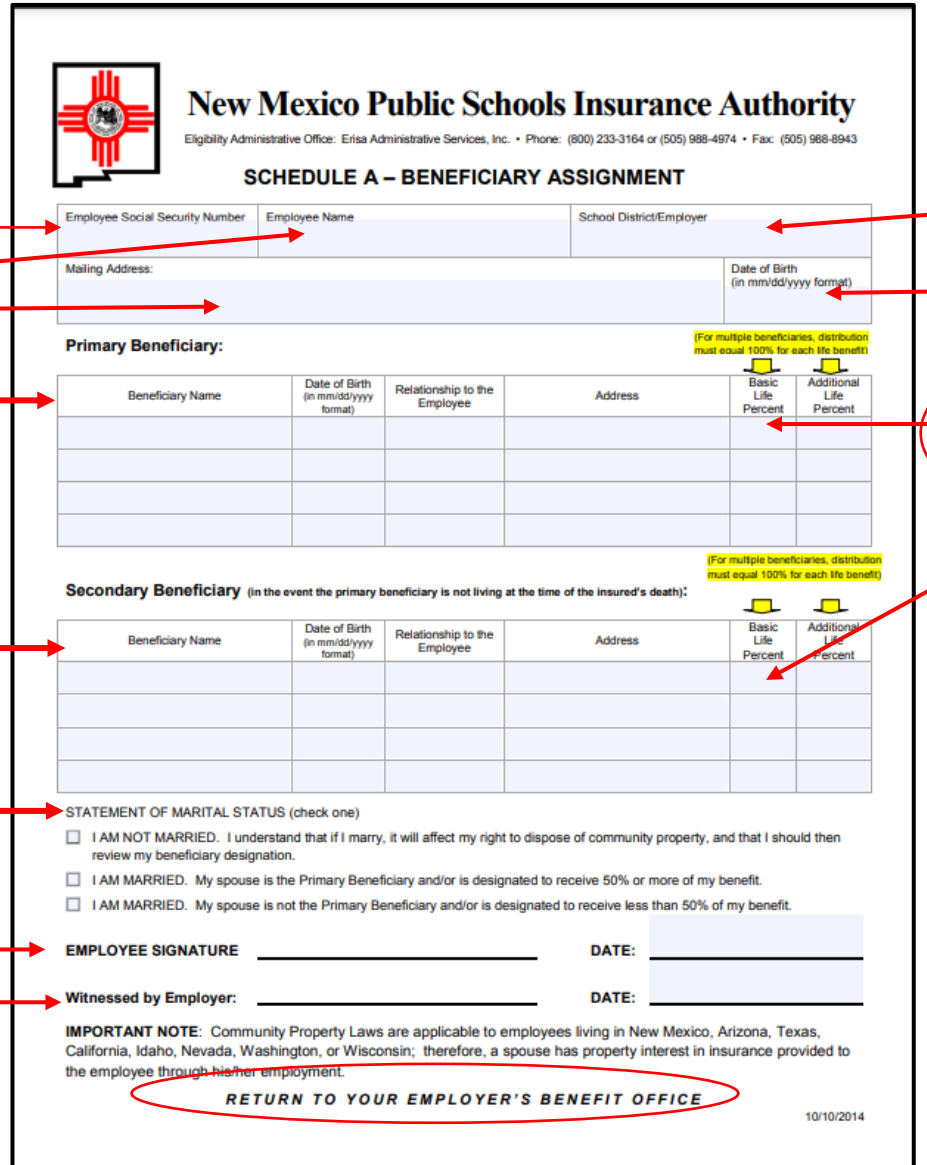
New Mexico Public Schools Insurance Authority

Schedule A – Beneficiary Assignment

https://nmpsia.com/pdfs/Schedule_A_Beneficiary_2013-10-10.pdf



New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

SCHEDULE A – BENEFICIARY ASSIGNMENT

Employee Social Security Number | Employee Name | School District/Employer

Mailing Address: | Date of Birth (in mm/dd/yyyy format)

Primary Beneficiary: (For multiple beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

Secondary Beneficiary (in the event the primary beneficiary is not living at the time of the insured's death): (For multiple beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in mm/dd/yyyy 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

Employee SSN

Employee Name

Mailing Address

Primary Beneficiary: Name, DOB,Relationship to Employee, Address

Secondary Beneficiary: Name, DOB,Relationship to Employee, Address

Statement of Marital Status (Check One)

Employee Signature and Date

Witnessed by Employer and Date

School District Employer Name

DOB (dd/mm/yyyy format)

For Multiple beneficiaries, distribution must equal 100% for each life benefit

Date stamp upon receipt

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New Mexico Public Schools Insurance Authority

Schedule B - State Filed Birth Certification

https://nmpsia.com/pdfs/Schedule_B_for_Birth_Registration_2013-01-17.pdf

Employee SSN
Employee Name

Birth Certificate Information
Complete 1 section per individual

Certificate Number

Employee Signature and date

Employer Signature and date

Reset Form

New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

SCHEDULE B - STATE FILED BIRTH CERTIFICATE REGISTRATION CERTIFICATION

This form is completed when an employee is enrolling dependent children.
Do not send copies of state publicly filed birth certificates.

Employee Social Security Number:	Employee Name:	School District / Employer:

1. Birth Certificate Information:

File No.:	Request No.:	County of Birth:
Date of Birth:	Date of Registration (in mm/dd/yyyy format):	
Name of Person Registered:	Sex:	
Name of Father:	Birth Name of Mother:	

CERTIFICATE NUMBER: _____

2 Birth Certificate Information:

File No.:	Request No.:	County of Birth:
Date of Birth:	Date of Registration (in mm/dd/yyyy format):	
Name of Person Registered:	Sex:	
Name of Father:	Birth Name of Mother:	

CERTIFICATE NUMBER: _____

3 Birth Certificate Information:

File No.:	Request No.:	County of Birth:
Date of Birth:	Date of Registration (in mm/dd/yyyy format):	
Name of Person Registered:	Sex:	
Name of Father:	Birth Name of Mother:	

CERTIFICATE NUMBER: _____

EMPLOYER CERTIFICATION: I attest, under penalty of perjury, that I have viewed the original State publicly filed Birth Certificate presented by the above employee, that it appears to be genuine and relates to the dependent requesting enrollment under this policy.

Employer's Insurance Representative **Date**

THIS FORM IS TURNED IN WITH THE EMPLOYEE'S ENROLLMENT APPLICATION /CHANGE CARD

09/14/2012

School District
Employer Name

File No.
Request No.
County of Birth
DOB
Date of Registration in mm/dd/yyyy format
Name of Person Registered
Sex
Name of Father
Birth Name of Mother

Date stamp upon receipt

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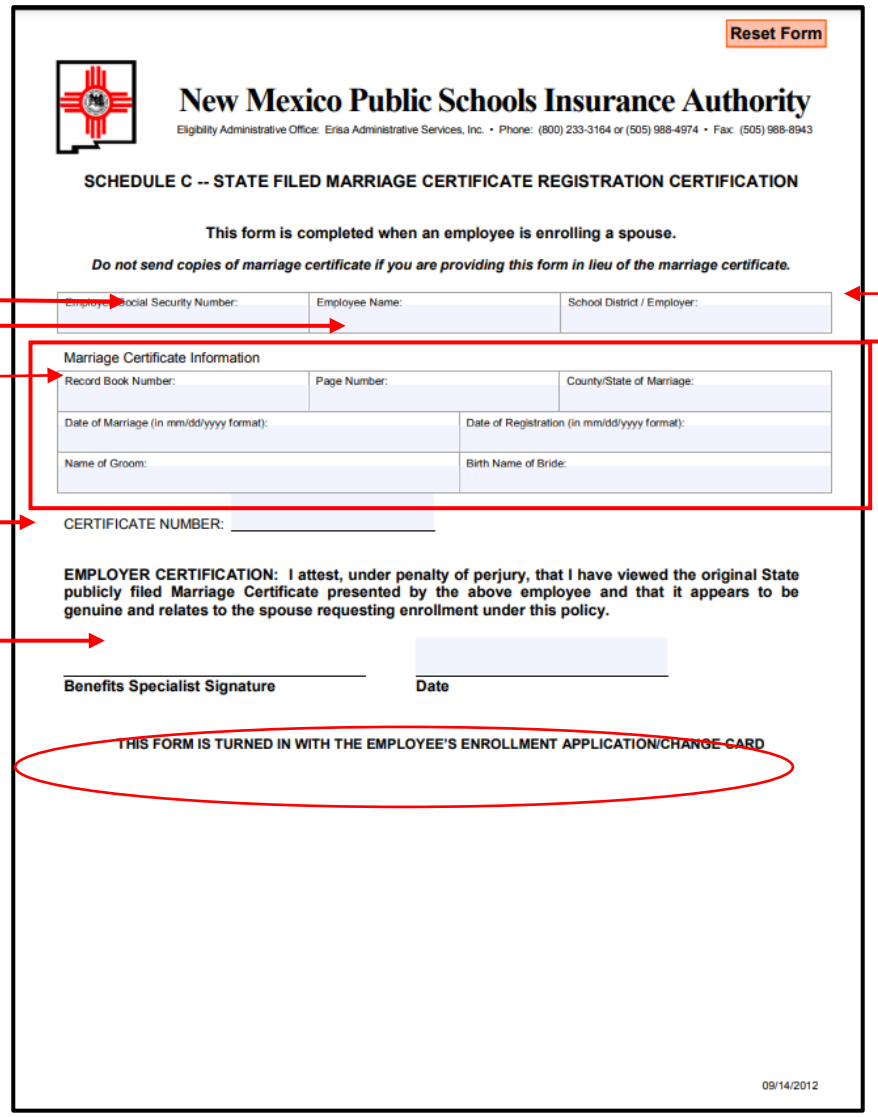
Schedule C – State Filed Marriage Registration Certification

https://nmpsia.com/pdfs/Schedule_C_for_Marriage_Registration_2013-01-17.pdf



Reset Form

New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

SCHEDULE C -- STATE FILED MARRIAGE CERTIFICATE REGISTRATION CERTIFICATION

This form is completed when an employee is enrolling a spouse.

Do not send copies of marriage certificate if you are providing this form in lieu of the marriage certificate.

Employee Social Security Number:	Employee Name:	School District / Employer:

Marriage Certificate Information

Record Book Number:	Page Number:	County/State of Marriage:

Date of Marriage (in mm/dd/yyyy format):	Date of Registration (in mm/dd/yyyy format):

Name of Groom:	Birth Name of Bride:

CERTIFICATE NUMBER: _____

EMPLOYER CERTIFICATION: I attest, under penalty of perjury, that I have viewed the original State publicly filed Marriage Certificate presented by the above employee and that it appears to be genuine and relates to the spouse requesting enrollment under this policy.

_____ _____

Benefits Specialist Signature **Date**

THIS FORM IS TURNED IN WITH THE EMPLOYEE'S ENROLLMENT APPLICATION/CHANGE CARD

09/14/2012

Employee SSN
Employee Name

Marriage Certificate Information

Certificate Number

Employer Certification
Benefits Specialist
Signature and Date

School District
Employer Name

Record Book Number
Page Number
County/State of Marriage
Date of Marriage mm/dd/yyyy format
Date of Registration mm/dd/yyyy format
Name of Groom
Birth Name of Bride

Date stamp upon receipt

Affidavit of Domestic Partnership (pg.1)

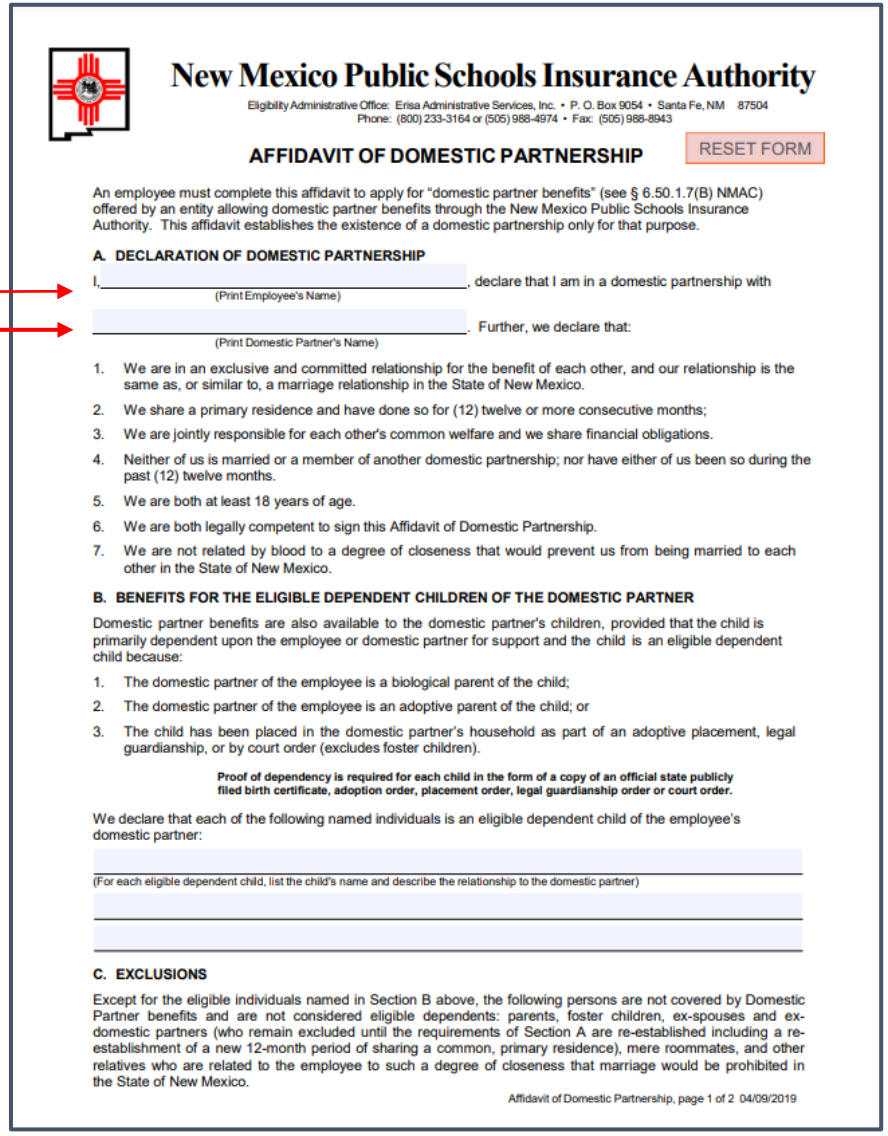
https://nmpsia.com/pdfs/Updated_Fillable_Affidavit_for_Domestic_Partnership_4.9.19.pdf

A. Declaration of Domestic Partnership

Print Employee's Name

Print Domestic Partner's Name

Eligible Dependent of Employee's Domestic Partner



New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • P. O. Box 9054 • Santa Fe, NM 87504
Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

AFFIDAVIT OF DOMESTIC PARTNERSHIP RESET FORM

An employee must complete this affidavit to apply for "domestic partner benefits" (see § 6.50.1.7(B) NMAC) offered by an entity allowing domestic partner benefits through the New Mexico Public Schools Insurance Authority. This affidavit establishes the existence of a domestic partnership only for that purpose.

A. DECLARATION OF DOMESTIC PARTNERSHIP

I, _____, declare that I am in a domestic partnership with
(Print Employee's Name)

_____. Further, we declare that:
(Print Domestic Partner's Name)

1. We are in an exclusive and committed relationship for the benefit of each other, and our relationship is the same as, or similar to, a marriage relationship in the State of New Mexico.
2. We share a primary residence and have done so for (12) twelve or more consecutive months;
3. We are jointly responsible for each other's common welfare and we share financial obligations.
4. Neither of us is married or a member of another domestic partnership; nor have either of us been so during the past (12) twelve months.
5. We are both at least 18 years of age.
6. We are both legally competent to sign this Affidavit of Domestic Partnership.
7. We are not related by blood to a degree of closeness that would prevent us from being married to each other in the State of New Mexico.

B. BENEFITS FOR THE ELIGIBLE DEPENDENT CHILDREN OF THE DOMESTIC PARTNER

Domestic partner benefits are also available to the domestic partner's children, provided that the child is primarily dependent upon the employee or domestic partner for support and the child is an eligible dependent child because:

1. The domestic partner of the employee is a biological parent of the child;
2. The domestic partner of the employee is an adoptive parent of the child; or
3. The child has been placed in the domestic partner's household as part of an adoptive placement, legal guardianship, or by court order (excludes foster children).

Proof of dependency is required for each child in the form of a copy of an official state publicly filed birth certificate, adoption order, placement order, legal guardianship order or court order.

We declare that each of the following named individuals is an eligible dependent child of the employee's domestic partner:

_____
(For each eligible dependent child, list the child's name and describe the relationship to the domestic partner)

_____

_____

C. EXCLUSIONS

Except for the eligible individuals named in Section B above, the following persons are not covered by Domestic Partner benefits and are not considered eligible dependents: parents, foster children, ex-spouses and ex-domestic partners (who remain excluded until the requirements of Section A are re-established including a re-establishment of a new 12-month period of sharing a common, primary residence), mere roommates, and other relatives who are related to the employee to such a degree of closeness that marriage would be prohibited in the State of New Mexico.

Affidavit of Domestic Partnership, page 1 of 2 04/09/2019

Erisa Administrative Services, Inc.

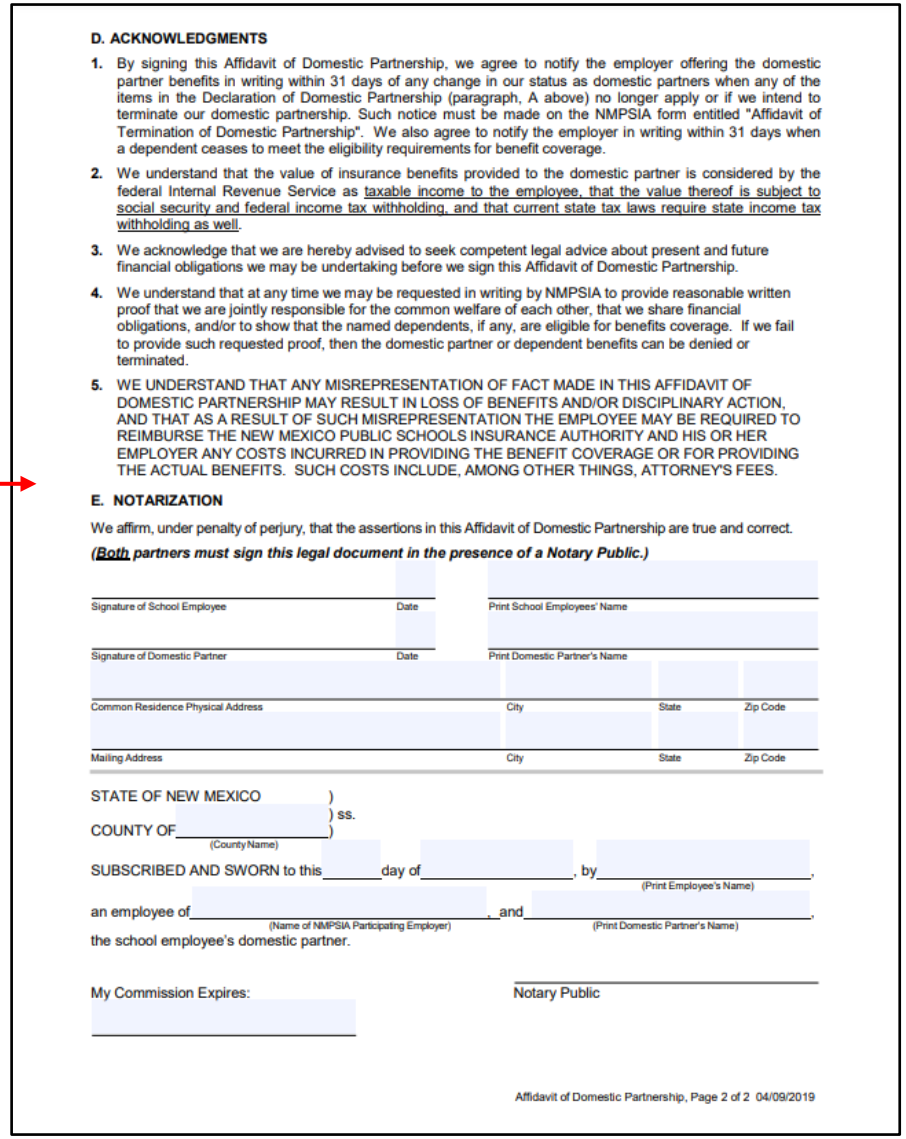
New Mexico Public Schools Insurance Authority

Affidavit of Domestic Partnership (pg.2)

https://nmpsia.com/pdfs/Updated_Fillable_Affidavit_for_Domestic_Partnership_4.9.19.pdf

Notarization

Both partners must sign this legal document in the presence of a Notary Public



D. ACKNOWLEDGMENTS

1. By signing this Affidavit of Domestic Partnership, we agree to notify the employer offering the domestic partner benefits in writing within 31 days of any change in our status as domestic partners when any of the items in the Declaration of Domestic Partnership (paragraph, A above) no longer apply or if we intend to terminate our domestic partnership. Such notice must be made on the NMPSIA form entitled "Affidavit of Termination of Domestic Partnership". We also agree to notify the employer in writing within 31 days when a dependent ceases to meet the eligibility requirements for benefit coverage.
2. We understand that the value of insurance benefits provided to the domestic partner is considered by the federal Internal Revenue Service as taxable income to the employee, that the value thereof is subject to social security and federal income tax withholding, and that current state tax laws require state income tax withholding as well.
3. We acknowledge that we are hereby advised to seek competent legal advice about present and future financial obligations we may be undertaking before we sign this Affidavit of Domestic Partnership.
4. We understand that at any time we may be requested in writing by NMPSIA to provide reasonable written proof that we are jointly responsible for the common welfare of each other, that we share financial obligations, and/or to show that the named dependents, if any, are eligible for benefits coverage. If we fail to provide such requested proof, then the domestic partner or dependent benefits can be denied or terminated.
5. WE UNDERSTAND THAT ANY MISREPRESENTATION OF FACT MADE IN THIS AFFIDAVIT OF DOMESTIC PARTNERSHIP MAY RESULT IN LOSS OF BENEFITS AND/OR DISCIPLINARY ACTION, AND THAT AS A RESULT OF SUCH MISREPRESENTATION THE EMPLOYEE MAY BE REQUIRED TO REIMBURSE THE NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY AND HIS OR HER EMPLOYER ANY COSTS INCURRED IN PROVIDING THE BENEFIT COVERAGE OR FOR PROVIDING THE ACTUAL BENEFITS. SUCH COSTS INCLUDE, AMONG OTHER THINGS, ATTORNEY'S FEES.

E. NOTARIZATION

We affirm, under penalty of perjury, that the assertions in this Affidavit of Domestic Partnership are true and correct.

(Both partners must sign this legal document in the presence of a Notary Public.)

Signature of School Employee | Date | Print School Employees' Name

Signature of Domestic Partner | Date | Print Domestic Partner's Name

Common Residence Physical Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____) (County Name)

SUBSCRIBED AND SWORN to this _____ day of _____, by _____ (Print Employee's Name),

an employee of _____ (Name of NMPSIA Participating Employer), and _____ (Print Domestic Partner's Name),

the school employee's domestic partner.

My Commission Expires: _____

Notary Public

Affidavit of Domestic Partnership, Page 2 of 2 04/09/2019

Date stamp upon receipt

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New Mexico Public Schools Insurance Authority

Affidavit of Termination of Domestic Partnership

https://nmpsia.com/pdfs/Updated_Fillable_Affidavit_for_Domestic_Partnership_4.9.19.pdf

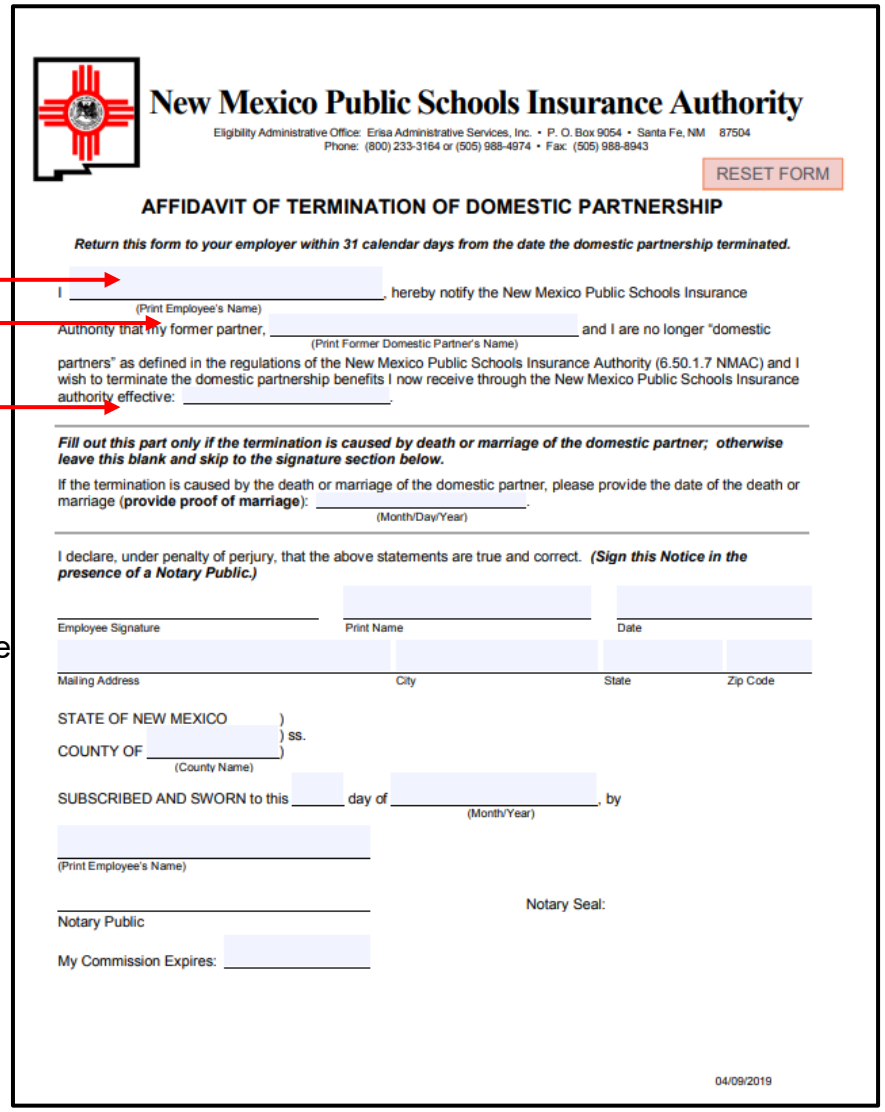
Print Employee's Name

Print Former Domestic Partner's Name

Effective Date of Termination

Notarization

Sign this legal document in the presence of a Notary Public



New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • P. O. Box 9054 • Santa Fe, NM 87504
Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

RESET FORM

AFFIDAVIT OF TERMINATION OF DOMESTIC PARTNERSHIP

Return this form to your employer within 31 calendar days from the date the domestic partnership terminated.

I _____, hereby notify the New Mexico Public Schools Insurance
(Print Employee's Name)
Authority that my former partner, _____ and I are no longer "domestic
(Print Former Domestic Partner's Name)
partners" as defined in the regulations of the New Mexico Public Schools Insurance Authority (6.50.1.7 NMAC) and I wish to terminate the domestic partnership benefits I now receive through the New Mexico Public Schools Insurance authority effective: _____.

Fill out this part only if the termination is caused by death or marriage of the domestic partner; otherwise leave this blank and skip to the signature section below.

If the termination is caused by the death or marriage of the domestic partner, please provide the date of the death or marriage (**provide proof of marriage**): _____.
(Month/Day/Year)

I declare, under penalty of perjury, that the above statements are true and correct. ***(Sign this Notice in the presence of a Notary Public.)***

Employee Signature | Print Name | Date

Mailing Address | City | State | Zip Code

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____)
(County Name)

SUBSCRIBED AND SWORN to this _____ day of _____, by
(Month/Year)

(Print Employee's Name)

Notary Public

Notary Seal:

My Commission Expires: _____

04/09/2019

Date stamp upon receipt

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Retiree Life Insurance Application

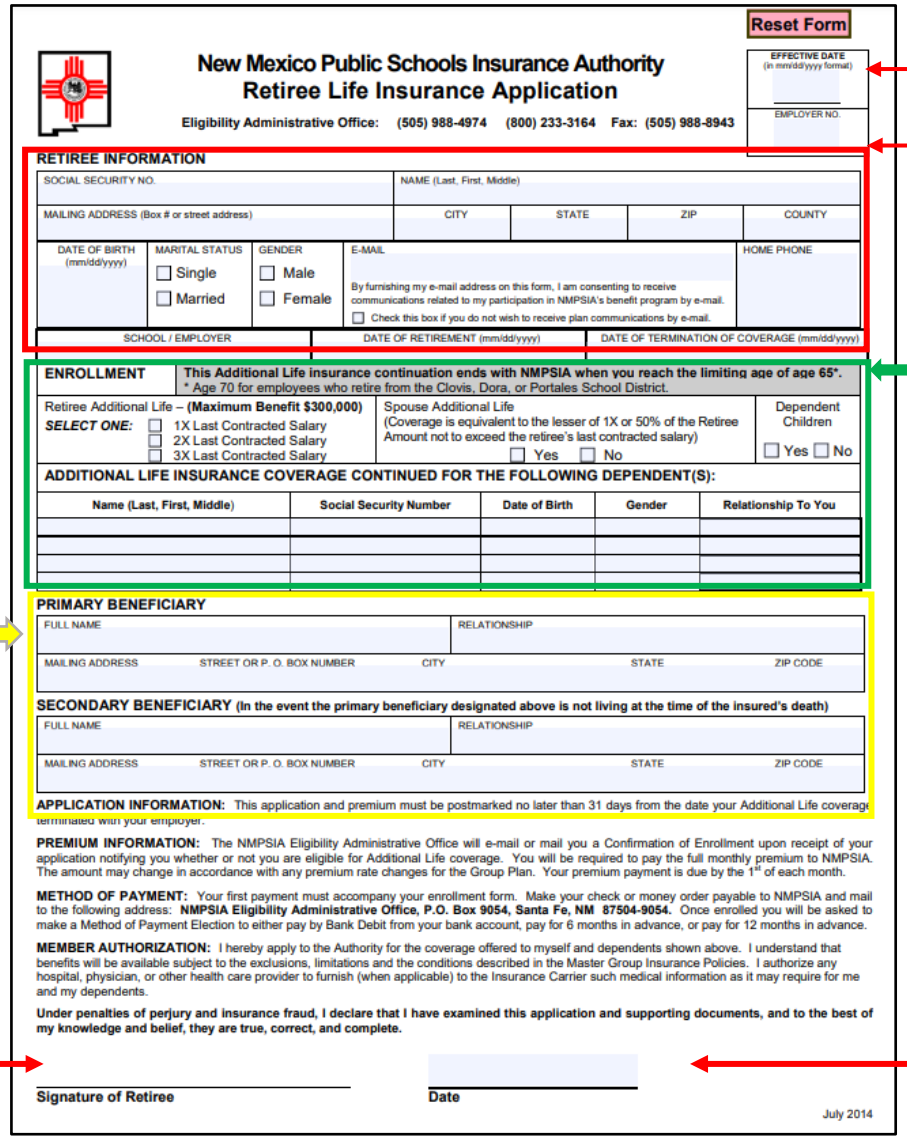
https://nmpsia.com/pdfs/Retiree_Application_2014-07.pdf

RETIREE INFORMATION

SSN, Name, Mailing Address Date of Birth, Marital Status Gender Email,Home Phone, School/Employer, Date of Retirement, Date of Termination of Coverage

PRIMARY BENEFICIARY
SECONDARY BENEFICIARY

Name, SSN, DOB, Gender, Relationship



Reset Form

New Mexico Public Schools Insurance Authority
Retiree Life Insurance Application

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

EFFECTIVE DATE (in mm/dd/yyyy format)
EMPLOYER NO.

RETIREE INFORMATION

SOCIAL SECURITY NO. | NAME (Last, First, Middle)
MAILING ADDRESS (Box # or street address) | CITY | STATE | ZIP | COUNTY
DATE OF BIRTH (mm/dd/yyyy) | MARITAL STATUS ☐ Single ☐ Married | GENDER ☐ Male ☐ Female | E-MAIL | HOME PHONE
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.
☐ Check this box if you do not wish to receive plan communications by e-mail.
SCHOOL / EMPLOYER | DATE OF RETIREMENT (mm/dd/yyyy) | DATE OF TERMINATION OF COVERAGE (mm/dd/yyyy)

ENROLLMENT
This Additional Life insurance continuation ends with NMPSIA when you reach the limiting age of age 65*.
* Age 70 for employees who retire from the Clovis, Dora, or Portales School District.

Retiree Additional Life – (Maximum Benefit $300,000)
SELECT ONE: ☐ 1X Last Contracted Salary ☐ 2X Last Contracted Salary ☐ 3X Last Contracted Salary

Spouse Additional Life
(Coverage is equivalent to the lesser of 1X or 50% of the Retiree Amount not to exceed the retiree's last contracted salary)
☐ Yes ☐ No

Dependent Children
☐ Yes ☐ No

ADDITIONAL LIFE INSURANCE COVERAGE CONTINUED FOR THE FOLLOWING DEPENDENT(S):

Name (Last, First, Middle)	Social Security Number	Date of Birth	Gender	Relationship To You

PRIMARY BENEFICIARY

FULL NAME | RELATIONSHIP
MAILING ADDRESS | STREET OR P. O. BOX NUMBER | CITY | STATE | ZIP CODE

SECONDARY BENEFICIARY (In the event the primary beneficiary designated above is not living at the time of the insured's death)

FULL NAME | RELATIONSHIP
MAILING ADDRESS | STREET OR P. O. BOX NUMBER | CITY | STATE | ZIP CODE

APPLICATION INFORMATION: This application and premium must be postmarked no later than 31 days from the date your Additional Life coverage terminated with your employer.

PREMIUM INFORMATION: The NMPSIA Eligibility Administrative Office will e-mail or mail you a Confirmation of Enrollment upon receipt of your application notifying you whether or not you are eligible for Additional Life coverage. You will be required to pay the full monthly premium to NMPSIA. The amount may change in accordance with any premium rate changes for the Group Plan. Your premium payment is due by the 1st of each month.

METHOD OF PAYMENT: Your first payment must accompany your enrollment form. Make your check or money order payable to NMPSIA and mail to the following address: **NMPSIA Eligibility Administrative Office, P.O. Box 9054, Santa Fe, NM 87504-9054.** Once enrolled you will be asked to make a Method of Payment Election to either pay by Bank Debit from your bank account, pay for 6 months in advance, or pay for 12 months in advance.

MEMBER AUTHORIZATION: I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that benefits 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 me and my dependents.

Under penalties of perjury and insurance fraud, I declare that I have examined this application and supporting documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature of Retiree | Date

July 2014

Effective Date

Employer No.

ENROLLMENT

Retiree Additional Life
Spouse Additional Life
Dependent Children?
Additional Life Insurance Coverage Continued for Following Dependents

* Age 70 for employees who retire from the Clovis, Dora, or Portales School District.

Signature of Retiree

Date

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Actively Serving Board Member Enrollment Application

https://nmpsia.com/pdfs/Board_Member_Enrollment_Application_2020-09.pdf

Section 1:
SSN, Name, DOB, Mailing Address, Marital Status, Gender, School District/Educational Entity you Represent, Date of Oath of Office

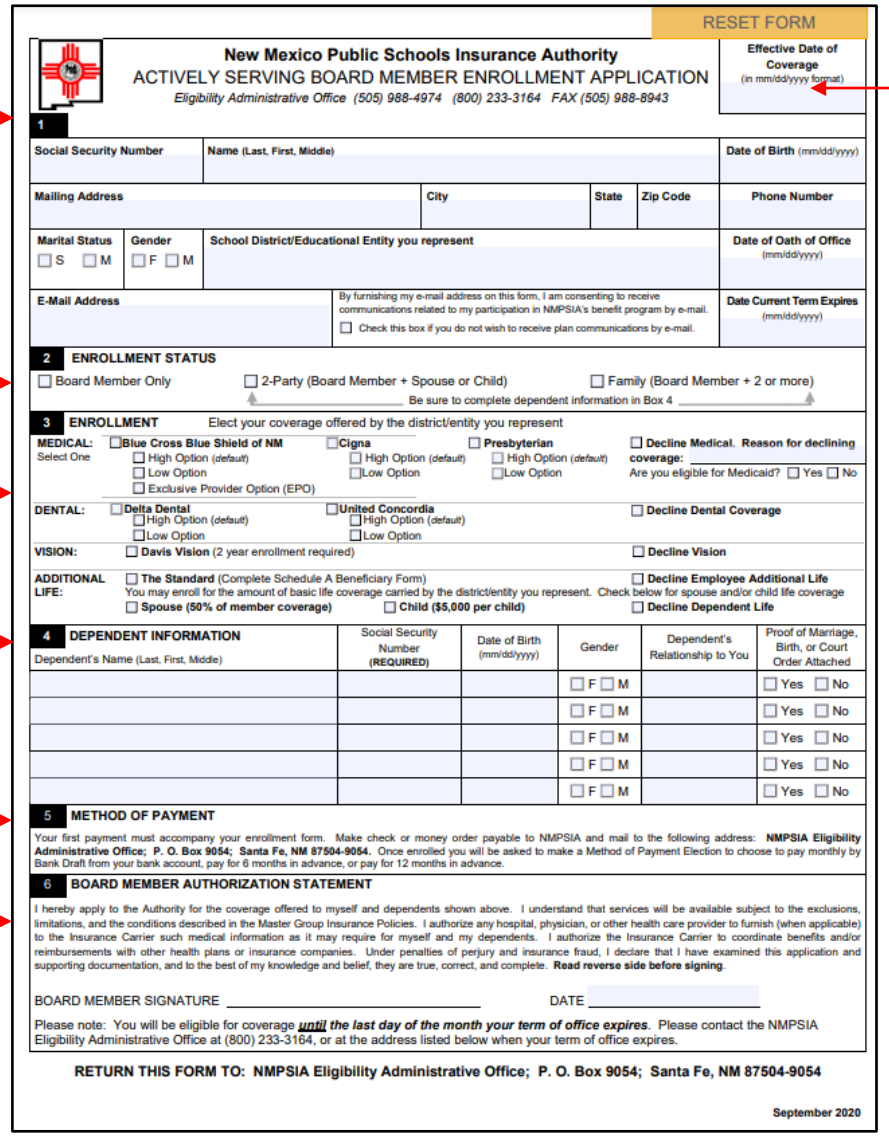
Section 2:
Enrollment Status

Section 3:
Enrollment

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

Section 5:
Method of Payment

Section 6:
Board Member Authorization Statement



RESET FORM

New Mexico Public Schools Insurance Authority
ACTIVELY SERVING BOARD MEMBER ENROLLMENT APPLICATION
Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943

Effective Date of Coverage (in mm/dd/yyyy format)

1

Social Security Number | Name (Last, First, Middle) | Date of Birth (mm/dd/yyyy)

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

Marital Status ☐S ☐M | Gender ☐F ☐M | School District/Educational Entity you represent | Date of Oath of Office (mm/dd/yyyy)

E-Mail Address | 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. ☐ Check this box if you do not wish to receive plan communications by e-mail. | Date Current Term Expires (mm/dd/yyyy)

2 ENROLLMENT STATUS

☐ Board Member Only ☐ 2-Party (Board Member + Spouse or Child) ☐ Family (Board Member + 2 or more)
Be sure to complete dependent information in Box 4

3 ENROLLMENT Elect your coverage offered by the district/entity you represent

MEDICAL: Select One
☐ Blue Cross Blue Shield of NM: ☐ High Option (default) ☐ Low Option ☐ Exclusive Provider Option (EPO)
☐ Cigna: ☐ High Option (default) ☐ Low Option
☐ Presbyterian: ☐ High Option (default) ☐ Low Option
☐ Decline Medical. Reason for declining coverage: _____ Are you eligible for Medicaid? ☐ Yes ☐ No

DENTAL:
☐ Delta Dental: ☐ High Option (default) ☐ Low Option
☐ United Concordia: ☐ High Option (default) ☐ Low Option
☐ Decline Dental Coverage

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

ADDITIONAL LIFE:
☐ The Standard (Complete Schedule A Beneficiary Form)
You may enroll for the amount of basic life coverage carried by the district/entity you represent. Check below for spouse and/or child life coverage
☐ Spouse (50% of member coverage) ☐ Child ($5,000 per child)
☐ Decline Employee Additional Life
☐ Decline Dependent Life

4 DEPENDENT INFORMATION

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
			☐F ☐M		☐Yes ☐No

5 METHOD OF PAYMENT

Your first payment must accompany your enrollment form. Make check or money order payable to NMPSIA and mail to the following address: **NMPSIA Eligibility Administrative Office; P. O. Box 9054; Santa Fe, NM 87504-9054.** Once enrolled you will be asked to make a Method of Payment Election to choose to pay monthly by Bank Draft from your bank account, pay for 6 months in advance, or pay for 12 months in advance.

6 BOARD MEMBER AUTHORIZATION STATEMENT

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.**

BOARD MEMBER SIGNATURE _____ DATE _____

Please note: You will be eligible for coverage ***until the last day of the month your term of office expires.*** Please contact the NMPSIA Eligibility Administrative Office at (800) 233-3164, or at the address listed below when your term of office expires.

RETURN THIS FORM TO: NMPSIA Eligibility Administrative Office; P. O. Box 9054; Santa Fe, NM 87504-9054

September 2020

Effective Date of Coverage

No retroactive effective dates allowed

Date Stamp Upon receipt

Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Member Authorization for Release of Health Information

https://nmpsia.com/pdfs/Release_of_Health_Information_1.12.2021.pdf

Member Name

A.Specific person /organization authorized provide the information

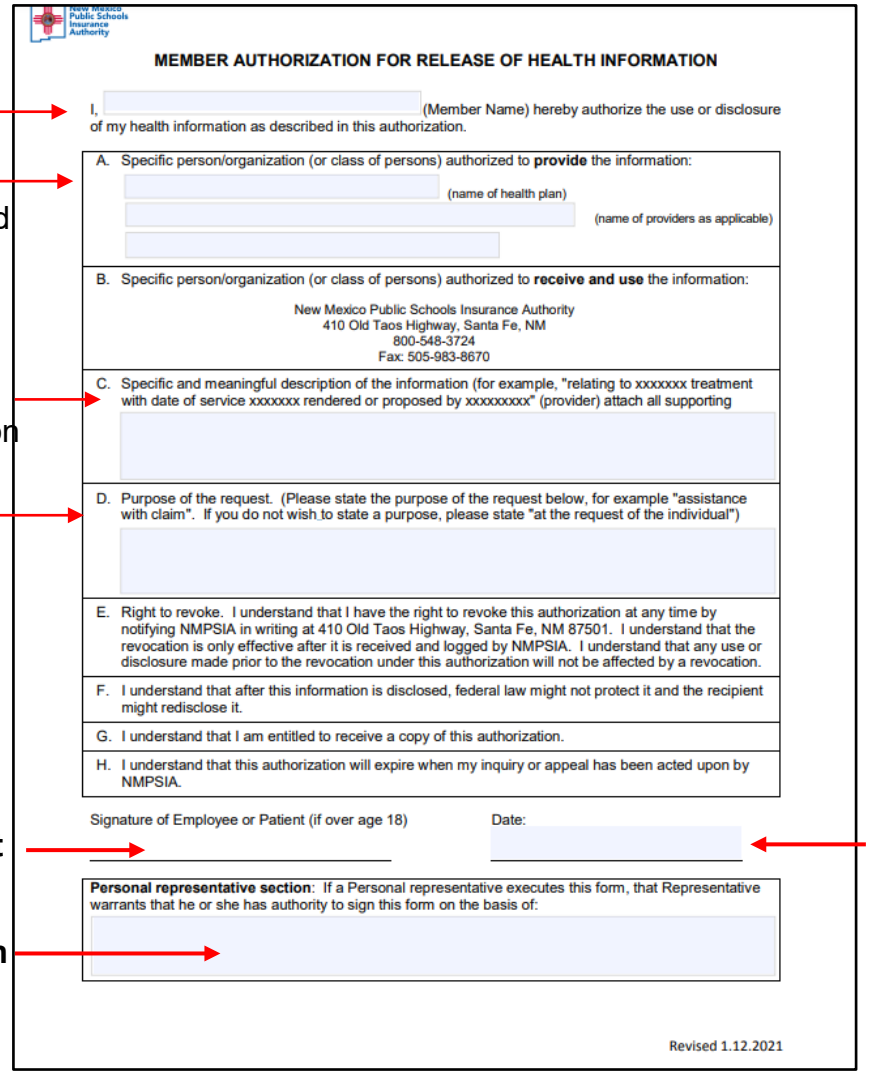
C. Specific and Meaningful description of the information

D. Purpose of the Request

Signature of Employee or Patient

Date

Personal Representative Section



MEMBER AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ (Member Name) hereby authorize the use or disclosure of my health information as described in this authorization.

A. Specific person/organization (or class of persons) authorized to **provide** the information:

_____ (name of health plan)

_____ (name of providers as applicable)

_____

B. Specific person/organization (or class of persons) authorized to **receive and use** the information:

New Mexico Public Schools Insurance Authority
410 Old Taos Highway, Santa Fe, NM
800-548-3724
Fax: 505-983-8670

C. Specific and meaningful description of the information (for example, "relating to xxxxxxx treatment with date of service xxxxxxx rendered or proposed by xxxxxxxxx" (provider) attach all supporting

D. Purpose of the request. (Please state the purpose of the request below, for example "assistance with claim". If you do not wish to state a purpose, please state "at the request of the individual")

E. Right to revoke. I understand that I have the right to revoke this authorization at any time by notifying NMPSIA in writing at 410 Old Taos Highway, Santa Fe, NM 87501. I understand that the revocation is only effective after it is received and logged by NMPSIA. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

F. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

G. I understand that I am entitled to receive a copy of this authorization.

H. I understand that this authorization will expire when my inquiry or appeal has been acted upon by NMPSIA.

Signature of Employee or Patient (if over age 18) _____ Date: _____

Personal representative section: If a Personal representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

Revised 1.12.2021

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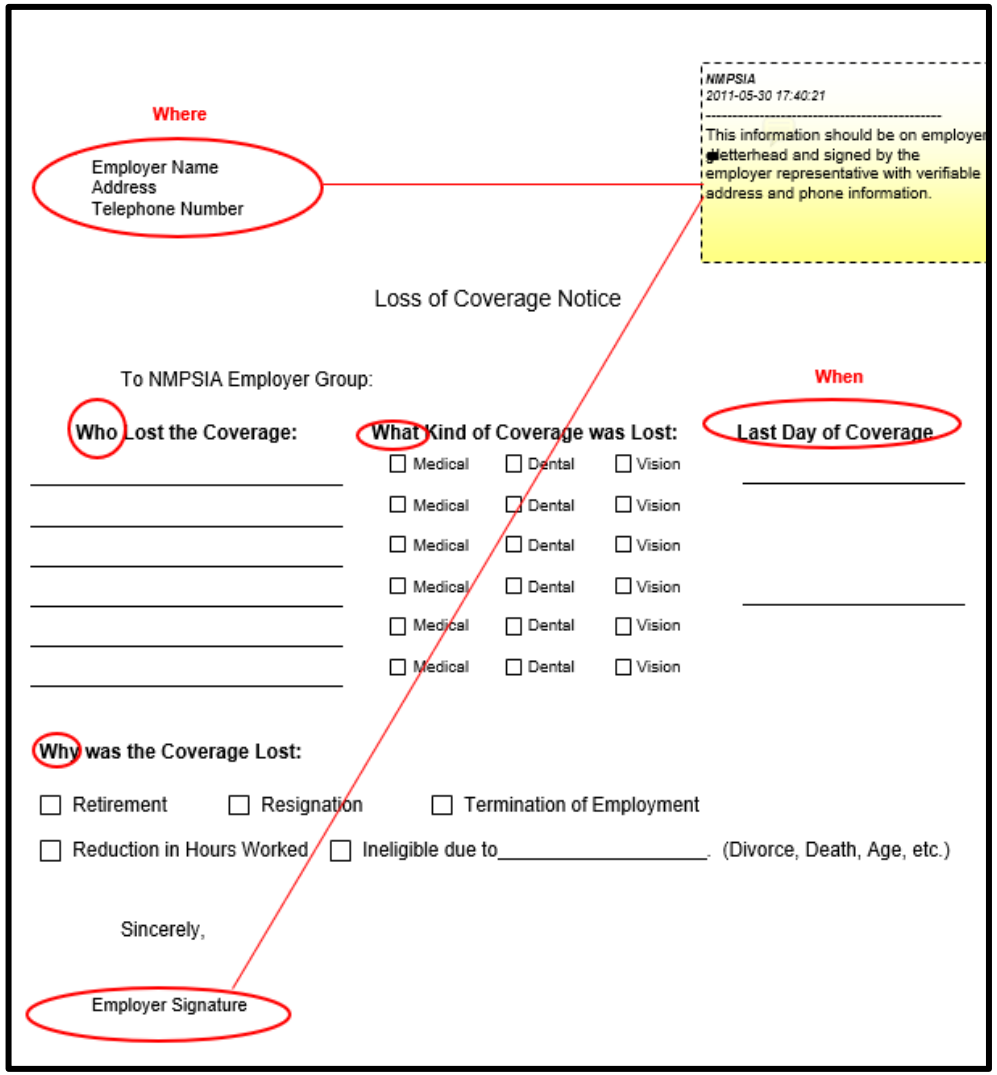
New Mexico Public Schools Insurance Authority

Sample Loss of Coverage Notice

https://nmpsia.com/pdfs/Sample_Loss_of_Coverage_Notice_Form.pdf



Where

Employer Name
Address
Telephone Number

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.

Loss of Coverage Notice

To NMPSIA Employer Group:

When

Who Lost the Coverage:

What Kind of Coverage was Lost:

Last Day of Coverage

_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ 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

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New Mexico Public Schools Insurance Authority

Part-Time Employee Resolution

https://nmpsia.com/pdfs/Sample_Part_Time_Resolution_Form_2013-05-02.pdf

School District/Entity Name

Starting/Ending School Year

District/Entity Name

District/Entity Name

District/Entity Name

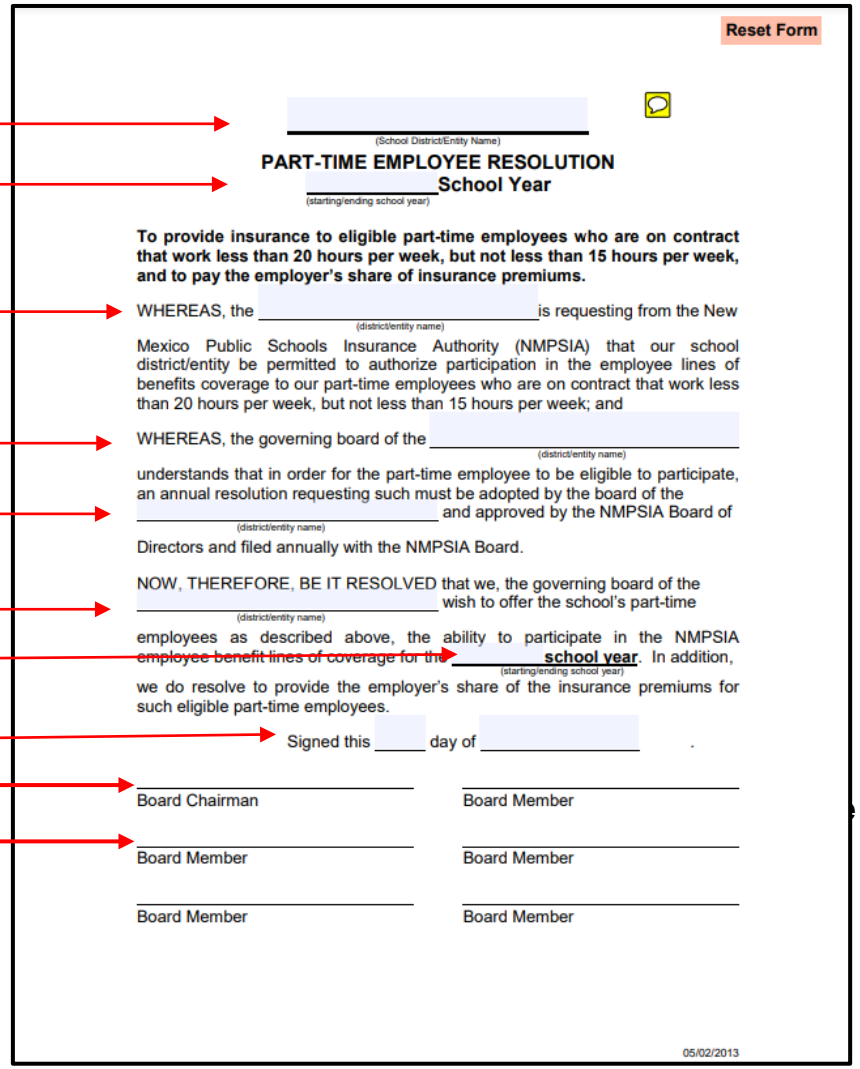
District/Entity Name

Starting/Ending School Year

Date

Board Chairman Signature

Board Member Signature(s)



Reset Form

(School District/Entity Name)

PART-TIME EMPLOYEE RESOLUTION

_____School Year

(starting/ending school year)

To provide insurance to eligible part-time employees who are on contract that work less than 20 hours per week, but not less than 15 hours per week, and to pay the employer's share of insurance premiums.

WHEREAS, the _____ (district/entity name) is requesting from the New Mexico Public Schools Insurance Authority (NMPSIA) that our school district/entity be permitted to authorize participation in the employee lines of benefits coverage to our part-time employees who are on contract that work less than 20 hours per week, but not less than 15 hours per week; and

WHEREAS, the governing board of the _____ (district/entity name) understands that in order for the part-time employee to be eligible to participate, an annual resolution requesting such must be adopted by the board of the _____ (district/entity name) and approved by the NMPSIA Board of Directors and filed annually with the NMPSIA Board.

NOW, THEREFORE, BE IT RESOLVED that we, the governing board of the _____ (district/entity name) wish to offer the school's part-time employees as described above, the ability to participate in the NMPSIA ~~employee benefit lines of coverage for the~~ _____ (starting/ending school year) **school year**. In addition, we do resolve to provide the employer's share of the insurance premiums for such eligible part-time employees.

Signed this _____ day of _____ .

Board Chairman _____ Board Member _____

Board Member _____ Board Member _____

Board Member _____ Board Member _____

05/02/2013

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New Mexico Public Schools Insurance Authority

Tips for Filling out Forms

- Carefully read through the instructions before completing the form
- Make sure the information on the form is clear and can be read
- Try to avoid stray marks, highlights or white out
- Use blue or black ink or type in the information
- Don’t cross things out or skip boxes

If you need help with the forms

Remember, your Erisa Benefits Representative can verify you have the applicable forms for your particular needs and review them for completion and accuracy.

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Quiz #1

What information is NOT required on a Schedule A Beneficiary form?

a) Employee Name
b) Employee Date of Birth
c) Employee Time of Birth

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Quiz #2

Who completes the Schedule B – State Filed Birth Certification?

a) Employee
b) Employee's Dependent
c) Employer
d) Employee and Employer

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Quiz #3

True or False:

An Affidavit of Termination of Domestic Partnership does not have to be notarized.

___ True

___ False

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New Mexico Public Schools Insurance Authority

Recognize Resources

NMPSIA Toolbox

- Employer's Local Policies
- NMPSIA Website and Program Guide
- Glossary of Terms and Acronyms
- Frequently Asked Questions (FAQ)
- Erisa Staff Resources

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Recognize Resources

Employer's Local Policies

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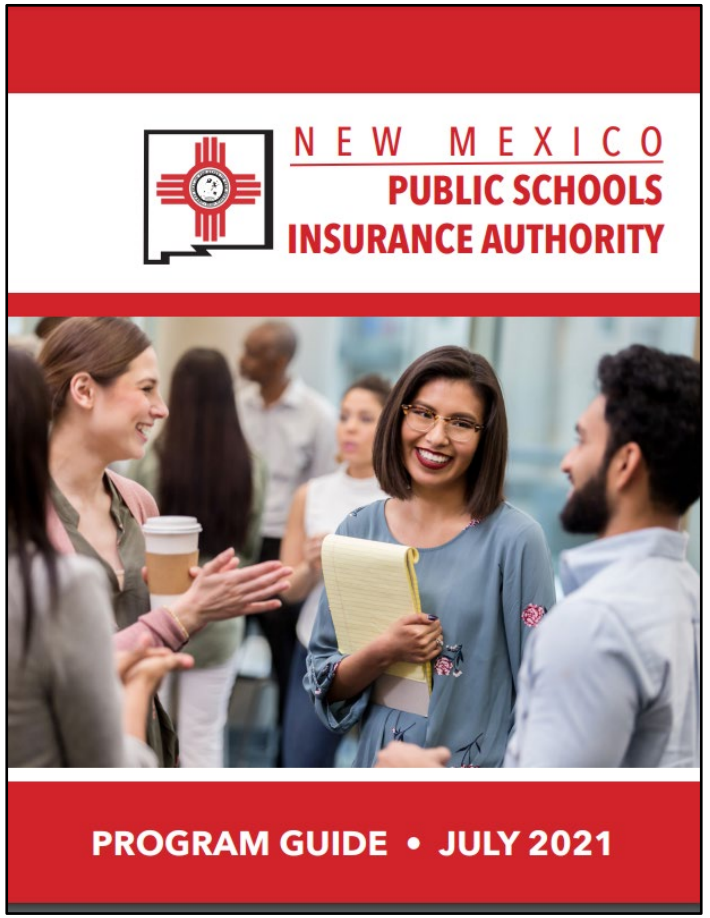
Recognize Resources

NMPSIA Website and Program Guide

Visit https://nmpsia.com/



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Recognize Resources

Glossary of Terms and Acronyms

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Acronym	Term	Definition
	2021 Change Card	Form used to report a Qualifying Event or change to an employees status or demographic information
	Affidavit for Domestic Partner	Affidavit used to apply for domestic partner benefits (only if employer participated in this benefit)
	Board Member Application	Actively Serving Board Member enrollment application
	Domestic Partnership	Two people of the same or opposite sex who share a domestic life but are not married or joined by a civil union.
	Employee Enrollment Application	Form completed by both employee and employer when enrolling in NMPSIA medical, dental, vision and life benefits
	Part-Time Resolution Template	Form used if employer elects to provide insurance to eligible part-time employees who are on contract that work less than 20 hours per week, but not less than 15 hours per week, and to pay the employer's share of insurance premiums.
	Release of Health Information	Form completed by member authorizing release of health information
	Retiree Life Insurance Application	Form completed by retiring employee who elects to continue life insurance benefits due to retirement (under 65)
	Sample Loss of Coverage Form	Form directing employee/employer as to required information on loss of coverage documentation
	Schedule A - Beneficiary Designation	Form completed by member assigning beneficiary(ies) for Basic and Additional Life Insurance benefits
	Schedule B - for Birth Certification	Form completed when an employee is enrolling dependent children in lieu of submitting state publicly filed birth certificates.
	Schedule C - for Marriage Certification	Form completed when an employee is enrolling a spouse in lieu of submitting a marriage certificate.
	Termination of Domestic Partner	Form completed and returned to employer within 31 days from the date domestic partnership terminated.
DEP	Dependent	A child or individual who can be claimed by employee
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
ER		Employer
FAQ	`	Frequently Asked Questions
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.
QE	Qualifying Event	A change in an employee's status

New Mexico Public Schools Insurance Authority

Recognize Resources

Frequently Asked Questions (FAQ)

Completing NMPSIA Forms
Employer Frequently Asked Questions

1. **Employee wants to add Additional Life, Spouse Life, Dependent Life and Long-Term Disability but is outside of his/her enrollment period, is a change card all that's needed?**
   No. Employee must complete an Evidence of Insurability form or EOI, as well as a change card. Once received, the EOI will be forwarded to the Standard for review.

2. **Are ALL district board members required to sign the Part-Time Resolution document for each year the request is made?**
   Yes. An annual resolution requesting such must be adopted by the board of the applicable district and approved by the NMPSIA Board of (district/entity name) Directors and filed annually with the NMPSIA Board.

3. **Can the Sample Loss of Coverage Notice be completed and signed by a healthcare provider in lieu of an official loss of coverage letter?**
   No. The Sample Loss of Coverage Notice is an "example" of the required information that must be included in a Loss of Coverage Notice on official letterhead and should not be used as a substitute.

4. **Does a Release of Health Information completed and signed by a Personal Representative have to include the document or Power of Attorney that makes him/her executor for the member's healthcare information?**
   Yes.

5. **While employed, a retiring employee has a beneficiary assignment on file with NMPSIA, does he/she still have to complete the Primary/Secondary Beneficiary Section(s) on the Retiree Life Insurance Application?**
   Yes, the beneficiary information section of the application must be completed, as often times information on prior forms is outdated or incomplete.

6. **A Domestic Partnership has turned into an official marriage, does member have to complete an Affidavit of Termination of Domestic Partnership?**
   Yes. If the termination is caused by the marriage of the domestic partner must report within 31 days and provide the date of marriage and proof of marriage.

7. **What dates go on the top right "Other Coverage Effective Date" box on the Employee Enrollment Application form, and must this box be filled in?**
   Coverage END dates (need to be at the end of the month) and coverage START dates (start at the beginning of the month). This box MUST be completed for every individual transaction.

8. **Whose signatures are required on the Affidavit of Domestic Partnership document?**
   Both partners signatures are required on this legal document in the presence of a Notary Public and his/her certification.

9. **Does an original marriage license suffice as verification for completion of Schedule C-State Filed Marriage Certificate Registration Certification?**

   No. Only the original State Publicly filed Marriage Certificate presented by the employee requesting enrollment under this policy.

10. **Whose name goes on Name of Person Registered on the Schedule B-State Filled Birth Certificate Registration Certification?**
    The name of the person for whom Birth Certificate is being certified.

EASI
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New Mexico Public Schools Insurance Authority

Erisa Staff Resources

Kathy Payanes
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kpayanes@easitpa.com

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Benefits Representative
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Angie Figueroa Perez
Receptionist
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Angelina Ortega
Benefits Representative
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Saraphina Scott
Benefits Representative
sscott@easitpa.com

Amy Bonal
Staff Accountant
abonal@easitpa.com

Erisa Administrative Services, Inc.
Santa Fe: (505) 988-4974 | Toll Free: (800) 233-3164, Option 1

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Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

NMPSIA Staff Resources

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Benefits/Wellness Manager
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1.800.548.3724, ext. 62940

Kaylei Jones
Benefits/Wellness Coordinator
kaylei.jones@psia.nm.gov
1.800.548.3724, ext. 62942

Leslie Martinez
Benefits Analyst
leslie.martinez@psia.nm.gov
1.800.548.3724, ext. 62941

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New Mexico Public Schools Insurance Authority

Recap

A review of this session

- ✓ Why you should follow certain guidelines when completing forms
- ✓ Filling out forms accurately is critical
- ✓ Different forms require different information relative to the circumstance

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