New Mexico Public Schools Insurance Authority

Evidence of Insurability (EOI)

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Today's Objectives

By the end of today's session, you should:

- Understand and articulate the Evidence of Insurability process
- Define the roles of the employee, employer, Erisa and the The Standard
- Gain additional knowledge of The Standard life products
- Simplify the process of submitting a life claim
- Recognize Available Resources

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

What is Evidence of Insurability (EOI)?

Evidence of Insurability (EOI), is the application process in which detailed health history on a Medical History Statement (MHS), regarding the condition of the applicants or dependent's health is submitted to The Standard to obtain certain insurance coverage(s).

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

When is EOI required?

EOI is required when applying for Additional Life (ADL), Spouse Life (SPLF) or Long Term Disability (LTD) coverage that was initially declined or if the employee chooses to enroll **after** the 31 day enrollment deadline.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Applying for ADL, SPLF or LTD Coverage

To add these coverages, the employee needs the following:

- **Employee Change Card**
- **EOI /MHS**
- **Approval by The Standard**

If applying for a spouse/domestic partner, a separate MHS must be submitted for him/her. An MHS is not required for children.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Steps to Applying for ADL, SPLF or LTD Coverage

Step 1

Employee completes the NMPSIA Employee Change Card and The Standard EOI/MHS and submits to Employer's Benefits Office

Step 2

Employer's Benefits Office submits both forms to Erisa.

Step 3

Erisa will expedite the forms to The Standard for review.

EASI
Erisa Administrative Services, Inc.

Employee Change Card

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

District Name and District Number

Select ADD COVERAGE

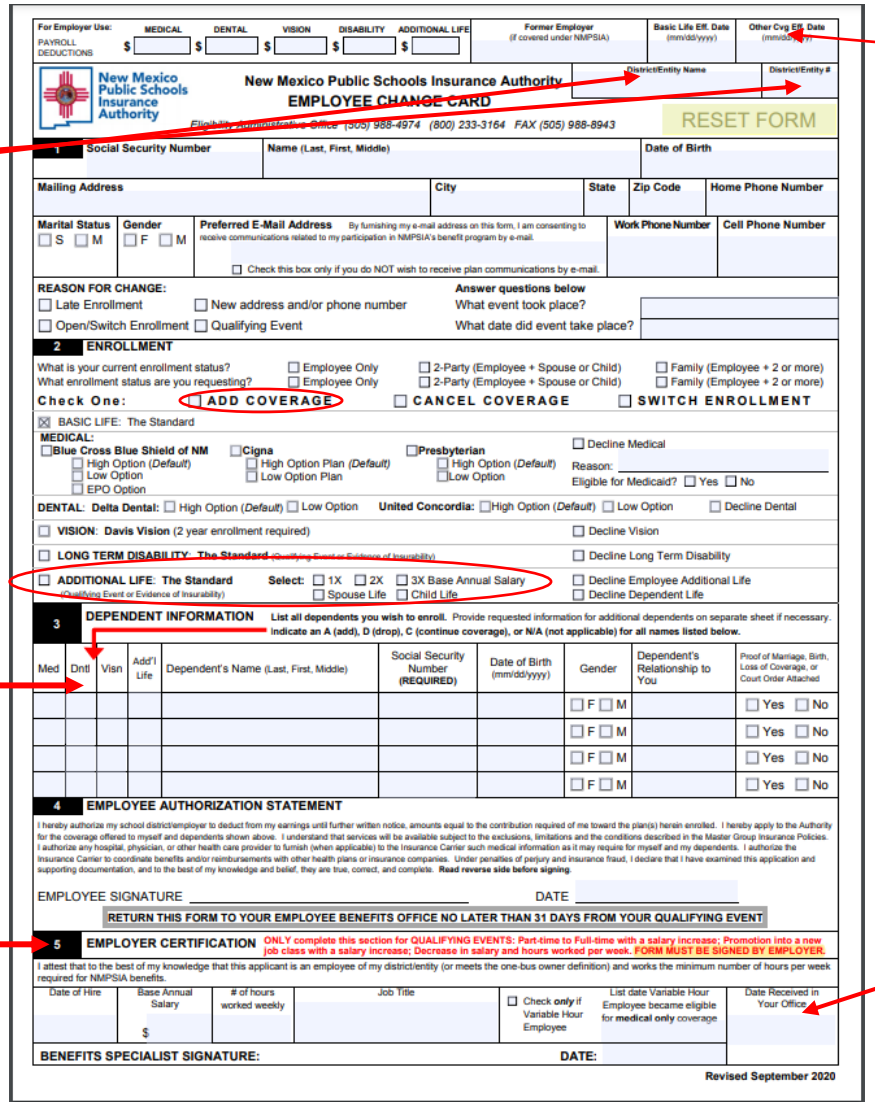
Select ADDITIONAL LIFE and 1X, 2X or 3X select Spouse Life and/or child if applicable

Add Dependent Information for all who would like to be considered for Additional Life benefits

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

The Standard will determine Start Date of coverage

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. ☐ Check this box only if you do NOT wish to receive plan communications by e-mail. | 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 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

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Where can the EOI/MHS form be found?

The Standard MHS can be located on the NMPSIA website at the following link:

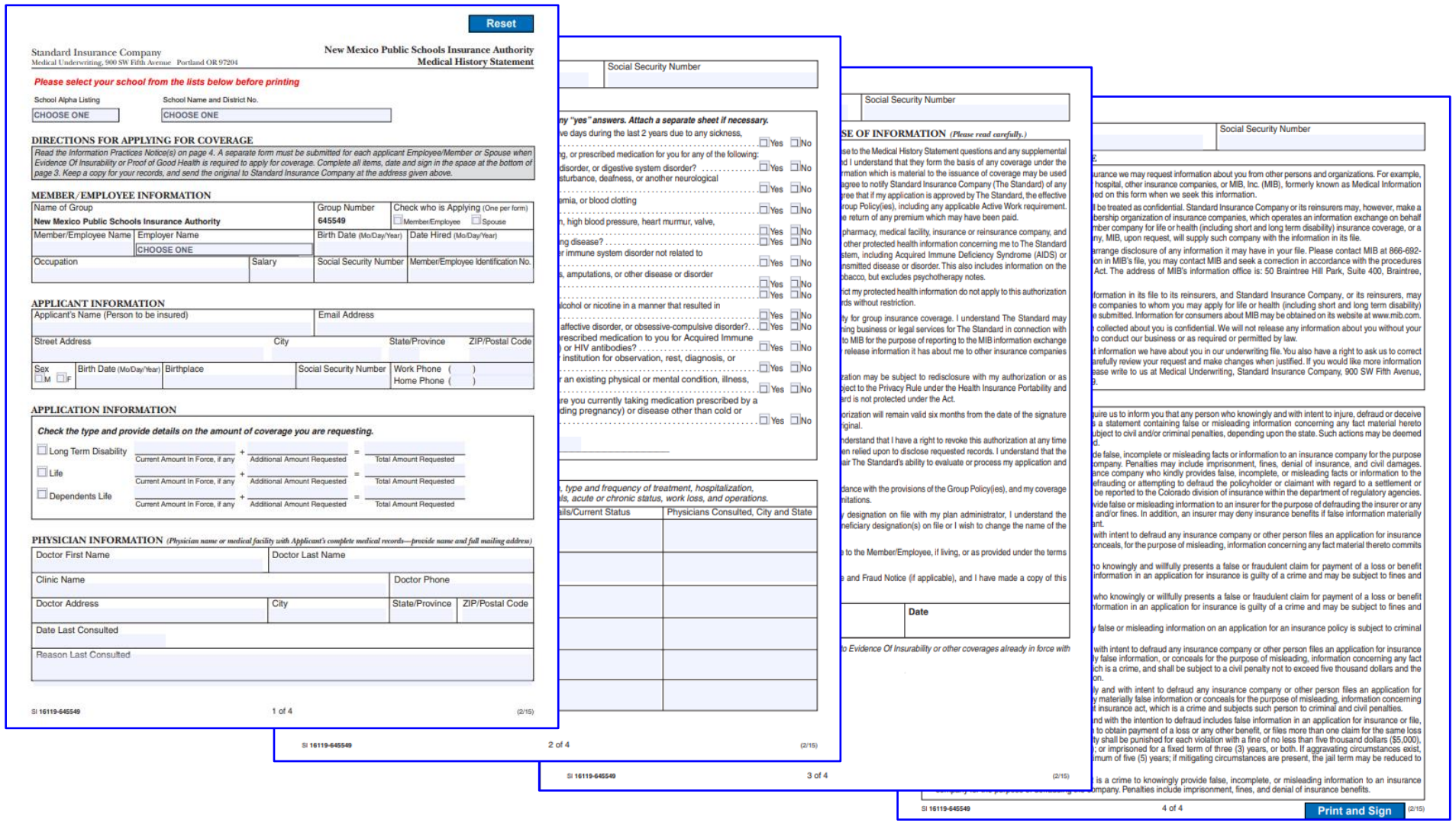
https://www.standard.com/eforms/16119_645549.pdf

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Medical History Statement (MHS)

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



Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

New Mexico Public Schools Insurance Authority
Medical History Statement

Reset

Please select your school from the lists below before printing

School Alpha Listing: CHOOSE ONE
School Name and District No.: CHOOSE ONE

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant Employee/Member or Spouse when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 3. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

MEMBER/EMPLOYEE INFORMATION

Name of Group: New Mexico Public Schools Insurance Authority
Group Number: 645549
Check who is Applying (One per form): Member/Employee Spouse
Member/Employee Name
Employer Name: CHOOSE ONE
Birth Date (Mo/Day/Year)
Date Hired (Mo/Day/Year)
Occupation
Salary
Social Security Number
Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)
Email Address
Street Address
City
State/Province
ZIP/Postal Code
Sex M F
Birth Date (Mo/Day/Year)
Birthplace
Social Security Number
Work Phone ( )
Home Phone ( )

APPLICATION INFORMATION

Check the type and provide details on the amount of coverage you are requesting.

Long Term Disability: Current Amount In Force, if any + Additional Amount Requested = Total Amount Requested
Life: Current Amount In Force, if any + Additional Amount Requested = Total Amount Requested
Dependents Life: Current Amount In Force, if any + Additional Amount Requested = Total Amount Requested

PHYSICIAN INFORMATION *(Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)*

Doctor First Name
Doctor Last Name
Clinic Name
Doctor Phone
Doctor Address
City
State/Province
ZIP/Postal Code
Date Last Consulted
Reason Last Consulted

SI 16119-645549 1 of 4 (2/15)

Social Security Number

ny "yes" answers. Attach a separate sheet if necessary.

ve days during the last 2 years due to any sickness, ☐Yes ☐No
g, or prescribed medication for you for any of the following:
disorder, or digestive system disorder? ☐Yes ☐No
sturbance, deafness, or another neurological ☐Yes ☐No
emia, or blood clotting ☐Yes ☐No
h, high blood pressure, heart murmur, valve, ☐Yes ☐No
ng disease? ☐Yes ☐No
r immune system disorder not related to ☐Yes ☐No
s, amputations, or other disease or disorder ☐Yes ☐No
☐Yes ☐No
lcohol or nicotine in a manner that resulted in ☐Yes ☐No
affective disorder, or obsessive-compulsive disorder? ☐Yes ☐No
rescribed medication to you for Acquired Immune ☐Yes ☐No
or HIV antibodies? ☐Yes ☐No
institution for observation, rest, diagnosis, or ☐Yes ☐No
an existing physical or mental condition, illness, ☐Yes ☐No
re you currently taking medication prescribed by a ding pregnancy) or disease other than cold or ☐Yes ☐No

type and frequency of treatment, hospitalization, s, acute or chronic status, work loss, and operations.

ils/Current Status | Physicians Consulted, City and State

SI 16119-645549 2 of 4 (2/15)

Social Security Number

SE OF INFORMATION *(Please read carefully.)*

se to the Medical History Statement questions and any supplemental
d I understand that they form the basis of any coverage under the
rmation which is material to the issuance of coverage may be used
agree to notify Standard Insurance Company (The Standard) of any
ree that if my application is approved by The Standard, the effective
roup Policy(ies), including any applicable Active Work requirement.
e return of any premium which may have been paid.
pharmacy, medical facility, insurance or reinsurance company, and
other protected health information concerning me to The Standard
stem, including Acquired Immune Deficiency Syndrome (AIDS) or
nsmitted disease or disorder. This also includes information on the
obacco, but excludes psychotherapy notes.
ict my protected health information do not apply to this authorization
rds without restriction.
ty for group insurance coverage. I understand The Standard may
ning business or legal services for The Standard in connection with
to MIB for the purpose of reporting to the MIB information exchange
release information it has about me to other insurance companies
cation may be subject to redisclosure with my authorization or as
ject to the Privacy Rule under the Health Insurance Portability and
rd is not protected under the Act.
orization will remain valid six months from the date of the signature
iginal.
nderstand that I have a right to revoke this authorization at any time
en relied upon to disclose requested records. I understand that the
air The Standard's ability to evaluate or process my application and
dance with the provisions of the Group Policy(ies), and my coverage
nitations.
y designation on file with my plan administrator, I understand the
neficiary designation(s) on file or I wish to change the name of the
to the Member/Employee, if living, or as provided under the terms
and Fraud Notice (if applicable), and I have made a copy of this

Date

o Evidence Of Insurability or other coverages already in force with

SI 16119-645549 3 of 4 (2/15)

Social Security Number

urance we may request information about you from other persons and organizations. For example, hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information ed on this form when we seek this information.
l be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a bership organization of insurance companies, which operates an information exchange on behalf mber company for life or health (including short and long term disability) insurance coverage, or a ny, MIB, upon request, will supply such company with the information in its file.
arrange disclosure of any information it may have in your file. Please contact MIB at 866-692- on in MIB's file, you may contact MIB and seek a correction in accordance with the procedures Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree,
formation in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may e companies to whom you may apply for life or health (including short and long term disability) e submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
collected about you is confidential. We will not release any information about you without your lo conduct our business or as required or permitted by law.
t information we have about you in our underwriting file. You also have a right to ask us to correct arefully review your request and make changes when justified. If you would like more information ease write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, d.
quire us to inform you that any person who knowingly and with intent to injure, defraud or deceive s a statement containing false or misleading information concerning any fact material hereto ubject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed d.
de false, incomplete or misleading facts or information to an insurance company for the purpose ompany. Penalties may include imprisonment, fines, denial of insurance, and civil damages. ance company who kindly provides false, incomplete, or misleading facts or information to the efrauding or attempting to defraud the policyholder or claimant with regard to a settlement or be reported to the Colorado division of insurance within the department of regulatory agencies.
wide false or misleading information to an insurer for the purpose of defrauding the insurer or any and/or fines. In addition, an insurer may deny insurance benefits if false information materially ant.
with intent to defraud any insurance company or other person files an application for insurance onceals, for the purpose of misleading, information concerning any fact material thereto commits
no knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit information in an application for insurance is guilty of a crime and may be subject to fines and
who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit nformation in an application for insurance is guilty of a crime and may be subject to fines and
y false or misleading information on an application for an insurance policy is subject to criminal
with intent to defraud any insurance company or other person files an application for insurance y false information, or conceals for the purpose of misleading, information concerning any fact ich is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the on.
y and with intent to defraud any insurance company or other person files an application for y materially false information or conceals for the purpose of misleading, information concerning f insurance act, which is a crime and subjects such person to criminal and civil penalties.
nd with the intention to defraud includes false information in an application for insurance or file, to obtain payment of a loss or any other benefit, or files more than one claim for the same loss ty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), ; or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, imum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to
is a crime to knowingly provide false, incomplete, or misleading information to an insurance ompany. Penalties include imprisonment, fines, and denial of insurance benefits.

SI 16119-645549 4 of 4 Print and Sign (2/15)

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

How is the EOI/MHS submitted?

Once completed, printed, signed and dated, the EOI/MHS(s) and the Employee Change Card must be submitted to the employer. The employer sends directly to Erisa. Erisa will submit to The Standard.

DO NOT submit any documents to The Standard. The Standard will not process claims received by an employee.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

How long does the underwriting process take?

The Standard's busy annual enrollment season runs from November through March each year. The initial review may take 8–12 weeks during these months.

For applications submitted February through September, you can expect a response in 4-6 weeks. Applications requiring additional information will take additional time.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

How will the applicant be informed of the decision?

Erisa will receive the decision from The Standard and will notify the employer. If the application is declined, the applicant will be told the medical reason(s) for the decision.

The medical reason(s) for the declination will not be shared with anyone but the applicant.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

When is approved coverage effective?

The coverage effective date is determined by The Standard and is always on the 1st day of the month following The Standard's approval.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

If application is declined, does existing coverage get cancelled by The Standard?

No. If some amount of coverage is already in force through a guaranteed issue provision, a declined decision will apply only to the portion of coverage that is actually subject to EOI.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Who should be contacted with any questions regarding the status or decision of an application?

All questions or inquiries regarding EOI applications must be directed to Erisa or The Standard.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

-Please Note-

The late enrollment process for ADL, SPLF and LTD applications can be submitted to Erisa at **ANY TIME** of the year.

An employee can apply for ADL, SPLF, and LTD during the NMPSIA Open/Switch Enrollment period, but the decision from The Standard may take longer.

An Employer should never discourage an employee from applying via EOI at anytime, but can recommend to apply between February and September for a faster decision.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Life Claims

EASI
Erisa Administrative Services, Inc.

Life Claim Submission Guide

https://nmpsia.com/pdfs/NMPSIA_Life_Claim_Submission_Guide_11.2020.pdf

Proof of Death Claim Form "POD"	This document is required to be completed by the **NMPSIA participating employer's authorized representative** on all life insurance claims, including dependent life insurance claims. Please fill out every field on the Proof of Death claim form to avoid delays during the review process. Please refer to the Life Insurance Benefits Application Instructions page of the claim form if you have additional questions. For further assistance completing the form, please contact your Standard Account Manager at 888.609.9763 ext. 0957.
Beneficiary Statement Form	The Beneficiary Statement form is generally completed by the beneficiary but in some situations, it may be completed by the guardian of a minor/trustee/estate representative, etc. Please include contact information for the beneficiary on the Proof of Death claim form. (i.e. name, Social Security number, date of birth, address, phone number and email address, if available.)
Enrollment Form	The Enrollment form is required by the Life Department to verify timely enrollment for contributory coverage(s). The Enrollment form is completed by the employee at initial Enrollment and for any elective increases. (This can include an enrollment form from a prior carrier plan.)
Beneficiary Designation	This document is completed, signed and dated by the employee designating a person or organization to receive the benefits in the event of his/her death. If no beneficiary designation exists, this must be noted in the remarks section of the Proof of Death claim form to prevent delays. Make sure a copy of the latest designation on file is submitted at point of claim filing.
Death Certificate	A copy of the final certified death certificate with final cause and manner of death is needed on all claims in order to establish proof of loss.
Funeral Assignment	Adult beneficiaries (over age 18) can direct The Standard to pay for the deceased's funeral expenses from their portion of their benefit by executing a Funeral Assignment. The assignment must reference the deceased's name, policy number, group name and must be signed and dated by the beneficiary(ies) of record. To honor the funeral assignment, it must be submitted with the claim.
Submit Claim to The Standard	All claim documents must be emailed to lifepro@standard.com with the Subject line "NMPSIA 645549 Life Claim for (deceased's name)".

Not Mandatory

Erisa Administrative Services, Inc.

Steps to Submitting a Life Claim

Process is initiated when a NMPSIA Participating Employer's Authorized Representative is notified of an employee or dependent's death.

Step 1

Employer Authorized Representative completes the Proof of Death Claim Form.

Step 2

Employer Authorized Representative prepares a packet to include the Proof of Death Claim Form, Beneficiary Statement, Employee Enrollment Form, and Copy of Death Certificate

Step 3

Employer Authorized Representative emails all claim documents for review to LifePro@Standard.com with Subject Line: NMPSIA 645549 Life Claim for (Deceased Name)

New Mexico Public Schools Insurance Authority

Proof of Death Claim Form

This document and all life insurance claims, including dependent life insurance claims are required to be completed by the **NMPSIA participating employer's authorized representative**.

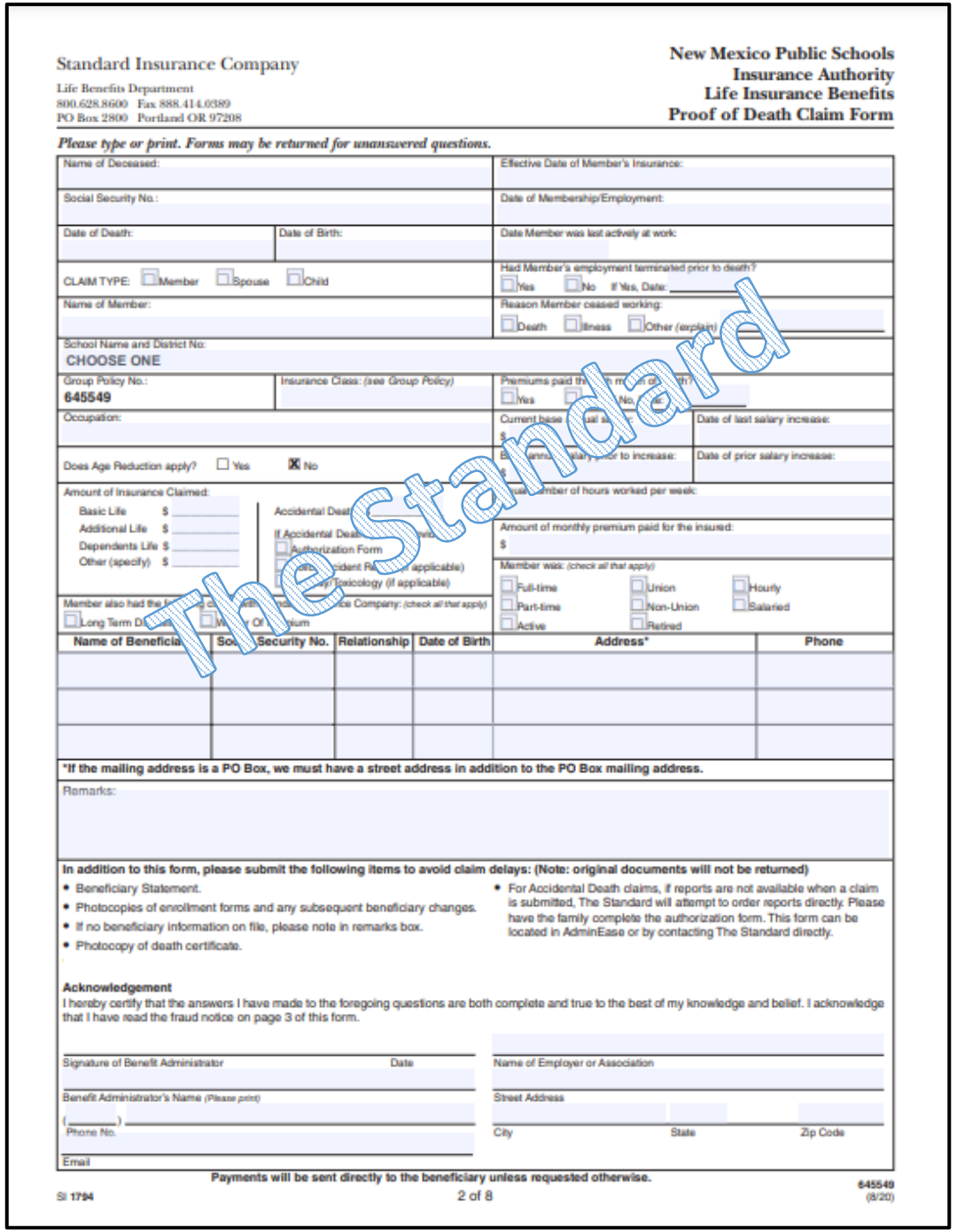
Fill out every field on the Proof of Death claim form to avoid delays during the review process.

Refer to the Life Insurance Benefits Application instruction page of the claim form if you have additional questions.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Proof of Death Claim Form



Standard Insurance Company

Life Benefits Department
800.628.8600 Fax 888.414.0389
PO Box 2800 Portland OR 97208

New Mexico Public Schools Insurance Authority
Life Insurance Benefits
Proof of Death Claim Form

Please type or print. Forms may be returned for unanswered questions.

Name of Deceased:

Effective Date of Member's Insurance:

Social Security No.:

Date of Membership/Employment:

Date of Death:

Date of Birth:

Date Member was last actively at work:

CLAIM TYPE: ☐ Member ☐ Spouse ☐ Child

Had Member's employment terminated prior to death? ☐ Yes ☐ No If Yes, Date:

Name of Member:

Reason Member ceased working: ☐ Death ☐ Illness ☐ Other (explain)

School Name and District No:
CHOOSE ONE

Group Policy No.:
645549

Insurance Class: (see Group Policy)

Premiums paid th[illegible] ☐ Yes ☐ No, [illegible]

Occupation:

Current base [illegible] $

Date of last salary increase:

Does Age Reduction apply? ☐ Yes ☒ No

[illegible] prior to increase: $

Date of prior salary increase:

Amount of Insurance Claimed:
Basic Life $
Additional Life $
Dependents Life $
Other (specify) $

Accidental Death

If Accidental Death [illegible]
☐ Authorization Form
☐ [illegible] Report (if applicable)
☐ [illegible]/Toxicology (if applicable)

[illegible] number of hours worked per week:

Amount of monthly premium paid for the insured:
$

Member also had the [illegible] Company: (check all that apply)
☐ Long Term Di[illegible] ☐ [illegible] Of [illegible]ium

Member was: (check all that apply)
☐ Full-time ☐ Union ☐ Hourly
☐ Part-time ☐ Non-Union ☐ Salaried
☐ Active ☐ Retired

Name of Beneficia	So[illegible] Security No.	Relationship	Date of Birth	Address*	Phone

*If the mailing address is a PO Box, we must have a street address in addition to the PO Box mailing address.

Remarks:

In addition to this form, please submit the following items to avoid claim delays: (Note: original documents will not be returned)

- Beneficiary Statement.
- Photocopies of enrollment forms and any subsequent beneficiary changes.
- If no beneficiary information on file, please note in remarks box.
- Photocopy of death certificate.
- For Accidental Death claims, if reports are not available when a claim is submitted, The Standard will attempt to order reports directly. Please have the family complete the authorization form. This form can be located in AdminEase or by contacting The Standard directly.

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Signature of Benefit Administrator Date

Name of Employer or Association

Benefit Administrator's Name (Please print)

Street Address

( ) Phone No.

City State Zip Code

Email

Payments will be sent directly to the beneficiary unless requested otherwise.

SI 1794 2 of 8 645549 (8/20)

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Beneficiary Statement Form

The Beneficiary Statement form is generally completed by the beneficiary. But in some situations, it may be completed by the guardian of a minor/trustee/estate representative, etc.

Include contact information for the beneficiary on the Proof of Death claim form (name, social security number, date of birth, address, phone number and email address, if available).

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Beneficiary Statement

Standard Insurance Company

Life Benefits Department
800.628.8600 Fax 888.414.0389
PO Box 2800 Portland OR 97208

New Mexico Public Schools
Insurance Authority
Life Insurance Benefits
Beneficiary Statement

AGREEMENT

I am claiming my share of the proceeds available under the Standard Insurance Company policy or policies. I agree that this Beneficiary Statement, a photocopy of the insured's death certificate and all other documents required by Standard Insurance Company in regard to my claim shall serve as proof of death of the insured. I also agree that, by providing this form, Standard Insurance Company does not waive any of its rights or defenses in regard to the payment of my claim.

IMPORTANT TAX INFORMATION

Taxpayer Identification Number — The Federal government requires us to report interest we pay you. Therefore, we are required to obtain your Social Security Number or Employer Identification Number, which you must certify under penalties of perjury. If you fail to supply us with an identification number, the Federal government requires us to withhold a portion of your interest as a deposit against the taxes that may be due.

Certification — Under Penalties Of Perjury, I Certify That:

1. My Social Security Number or Employer Identification Number shown on this form is my correct Taxpayer Identification Number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. person (includes a U.S. resident alien); and
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

Certification Instructions — You must check this box if the IRS has notified you that you are subject to backup withholding. ☐

If you are not a U.S. citizen, U.S. resident alien or other U.S. person, you must submit the applicable Form W-8 to certify your foreign status and, if applicable, claim treaty benefits.

We may contact you for more information if there are questions about your Taxpayer Identification Number or backup withholding status, or if you are a non-resident alien or foreign entity.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

METHOD OF PAYMENT

☐ **1. Payment by Check**

Funds under $25,000 are paid for policies issued in and for residents of California, Florida, Kentucky, Louisiana, Maryland and Rhode Island, payment will be made as a lump sum check to the beneficiary unless requested otherwise.

☐ **2. Payment by SSA**

☐ **3. Lump Sum Check**

Beneficiaries may receive their funds of $25,000 and above via Standard Secure Access (SSA) in accordance with the terms of the Group Policy. SSA is a convenient, interest-bearing checking account in which life insurance proceeds are deposited. With SSA, you are able to earn interest on the life insurance proceeds while taking the time to weigh important financial decisions that often follow the death of a loved one.

The beneficiary will be mailed a checkbook, once the claim is approved. In addition, all SSA accountholders have access to 24-hour customer service via a voice response unit (VRU) and a dedicated customer service team.

If you decide to assign a portion of your benefits to a funeral home, please include a notarized assignment form *(supplied by the funeral home)* and an itemized copy of the funeral bill. A separate check for the amount of the assignment will be delivered directly to the funeral home.

ACKNOWLEDGEMENT AND SIGNATURE

Name *(please print)* | Date of Birth

Beneficiary's Social Security No./Employer Identification No. *(required)* | Relationship to Deceased

Mailing Address *(if this is a PO Box, a street address is required)* | City | State | Zip Code

Street Address *(only if your mailing address is a PO Box)* | City | State | Zip Code

Cell/Work Phone No. | Home Phone No.

I certify that the statements made above are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

Signature of Beneficiary/Representative *(please use dark ink and sign as you would a check) If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.* | Date

Internal Use Only Claim Number: Claim Analyst:

Policyholder Use Only Name of Deceased: Group Policy No.: 645549

SI 1794 4 of 8 645549 (8/20)

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Employee Enrollment Form

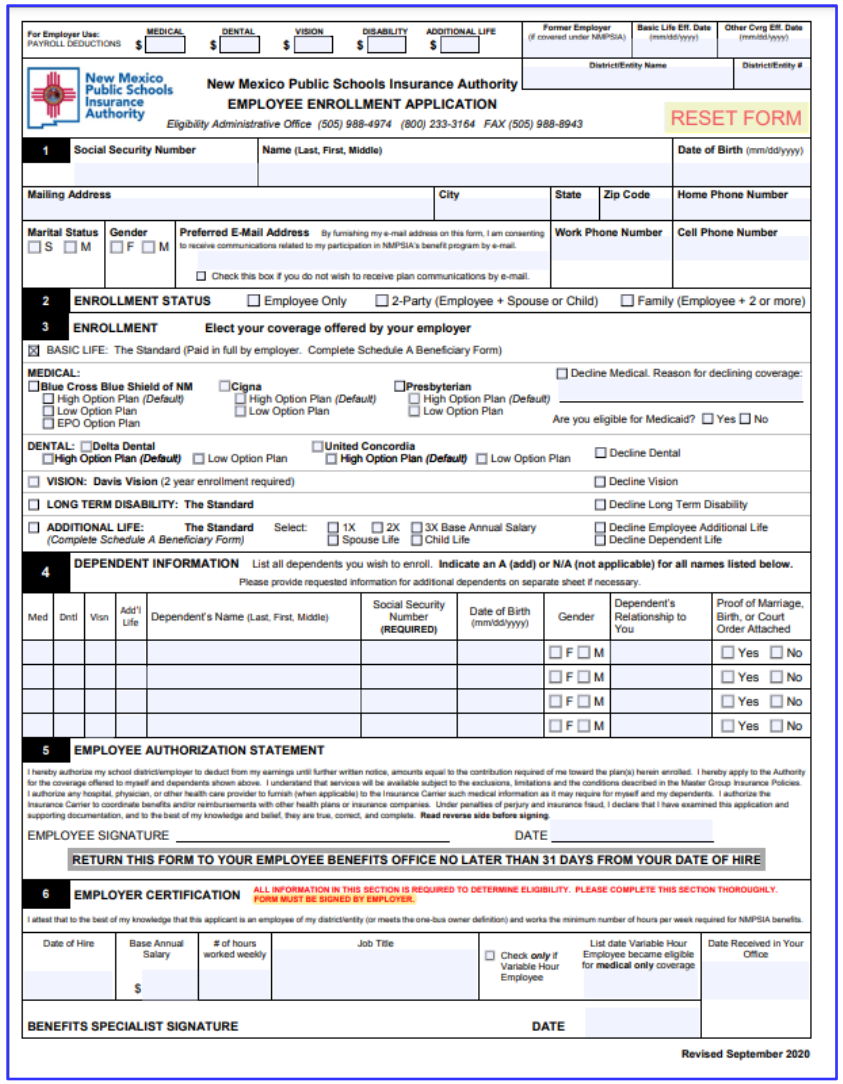
The NMPSIA Employee Enrollment Application is required by The Standard to verify timely enrollment for all Standard products.

The enrollment form is completed by the employee at initial enrollment and for any elective increases.

EASI
Erisa Administrative Services, Inc.

Employee Enrollment Application

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



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

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 — 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. | 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: ☐ 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

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Beneficiary Designation

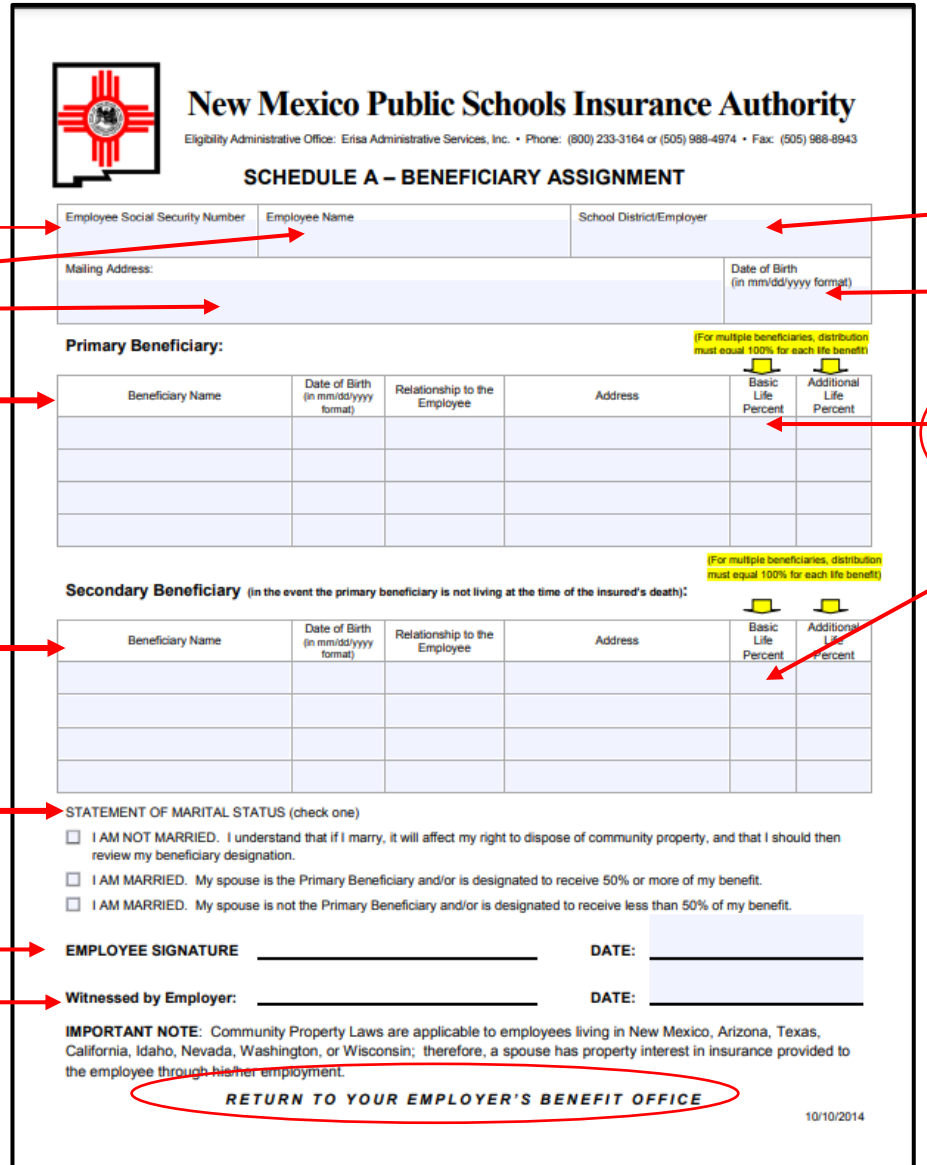
This document is completed, signed and dated by the employee designating a person or organization to receive the benefits in the event of his/her death. If no beneficiary designation exists, the next of kin will be notified.

Make sure the copy of the latest designation on file is submitted at time of claim filing.

EASI
Erisa Administrative Services, Inc.

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

Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

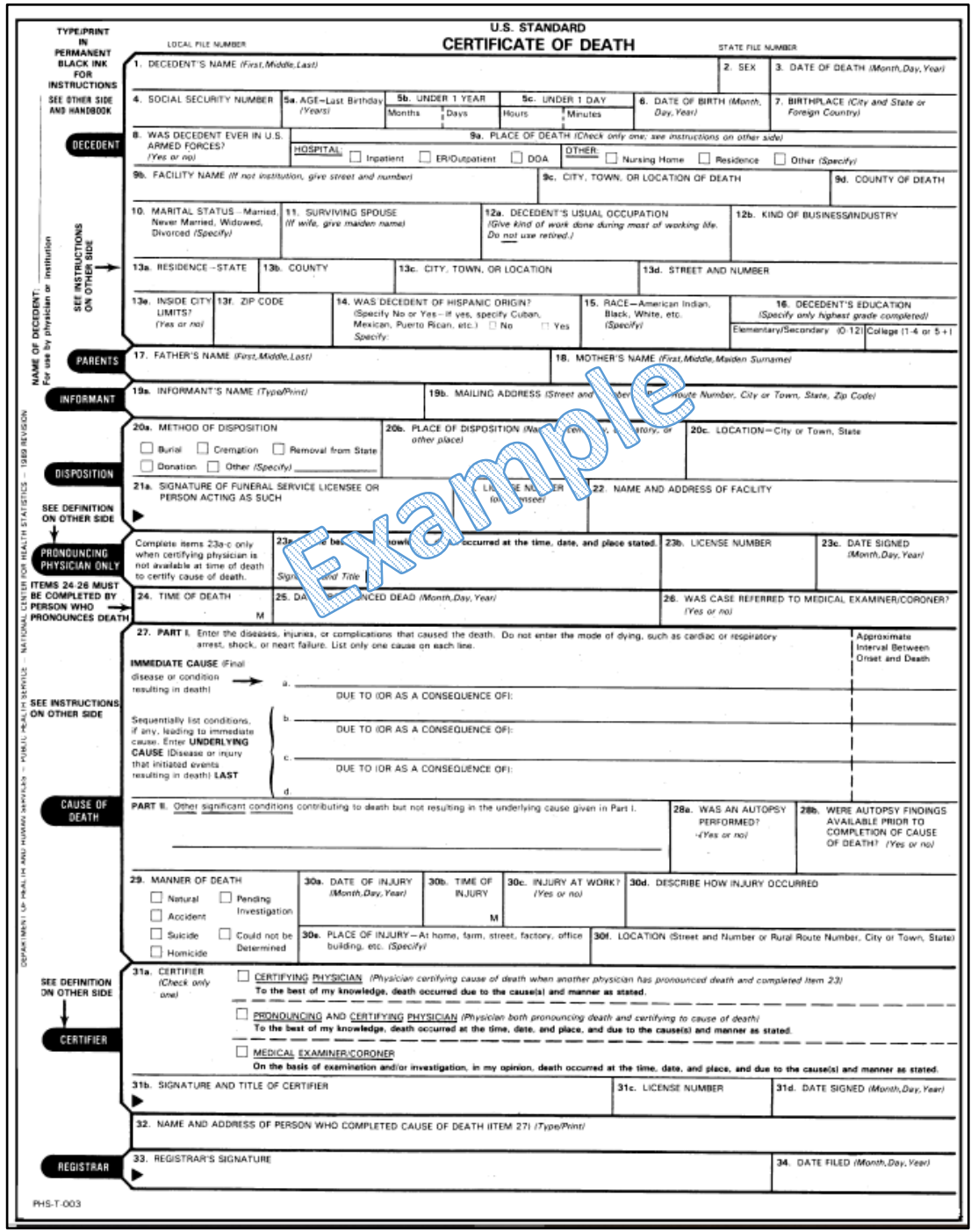
Death Certificate

A copy of the final certified death certificate with the final cause and manner of death is needed on all claims in order to establish proof of loss.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Death Certificate (Example)



EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Funeral Assignment

When applicable, adult beneficiaries (over age 18) can authorize The Standard to pay for the deceased's funeral expenses from their portion of their benefit by executing a Funeral Assignment. The assignment must reference the deceased's name, policy number, group name and must be signed and dated by the beneficiary(ies) of record.

To honor the funeral assignment, it must be submitted with the claim.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Funeral Assignment (Example)

ASSIGNMENT OF PROCEEDS OF INSURANCE

TO:_____
(INSURANCE COMPANY)

_____

_____

I, _____, being entitled to receive benefits
(Beneficiary)
under Policy Number _____
issued by _____, on the life
of_____, now deceased, and
having contracted with and being i[illegible] t[illegible]
(Funeral Home)
_____ of _____
(City – State)
For funeral se[illegible]ces an[illegible]rchandise for the deceased in the amount of:
_____Dollars ($_____),
Do hereby set ove[illegible], assign and transfer unto said Funeral Director the sum of
_____Dollars ($_____),
out of the proceeds of said Insurance Policy; and I hereby authorize and direct said Insurance Company to make its check payable to said Funeral Director for the assigned amount and to pay the remainder of the proceeds of said Insurance Policy, if any, to me. A statement of charges for funeral expenses for the deceased is attached hereto._____
(Beneficiary)

Address_____

_____
(Funeral Director Responsible)

_____

_____
(Signature of Funeral Director)

Date Signed_____

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Submit Claim to The Standard

All life claim documents must be e-mailed by the employer's benefits representative to lifepro@standard.com with the Subject Line: ***"NMPSIA 645549 Life Claim for (Deceased's Name)".***

EASI
Erisa Administrative Services, Inc.

Recognize Resources

NMPSIA Toolbox

- Employer's Local Policies
- NMPSIA Website and Program Guide
- Glossary of Terms and Acronyms
- Frequently Asked Questions (FAQ)
- Tips for Filling out Forms
- Erisa/The Standard Staff Resources

New Mexico Public Schools Insurance Authority

Employer's Local Policies

EASI
Erisa Administrative Services, Inc.

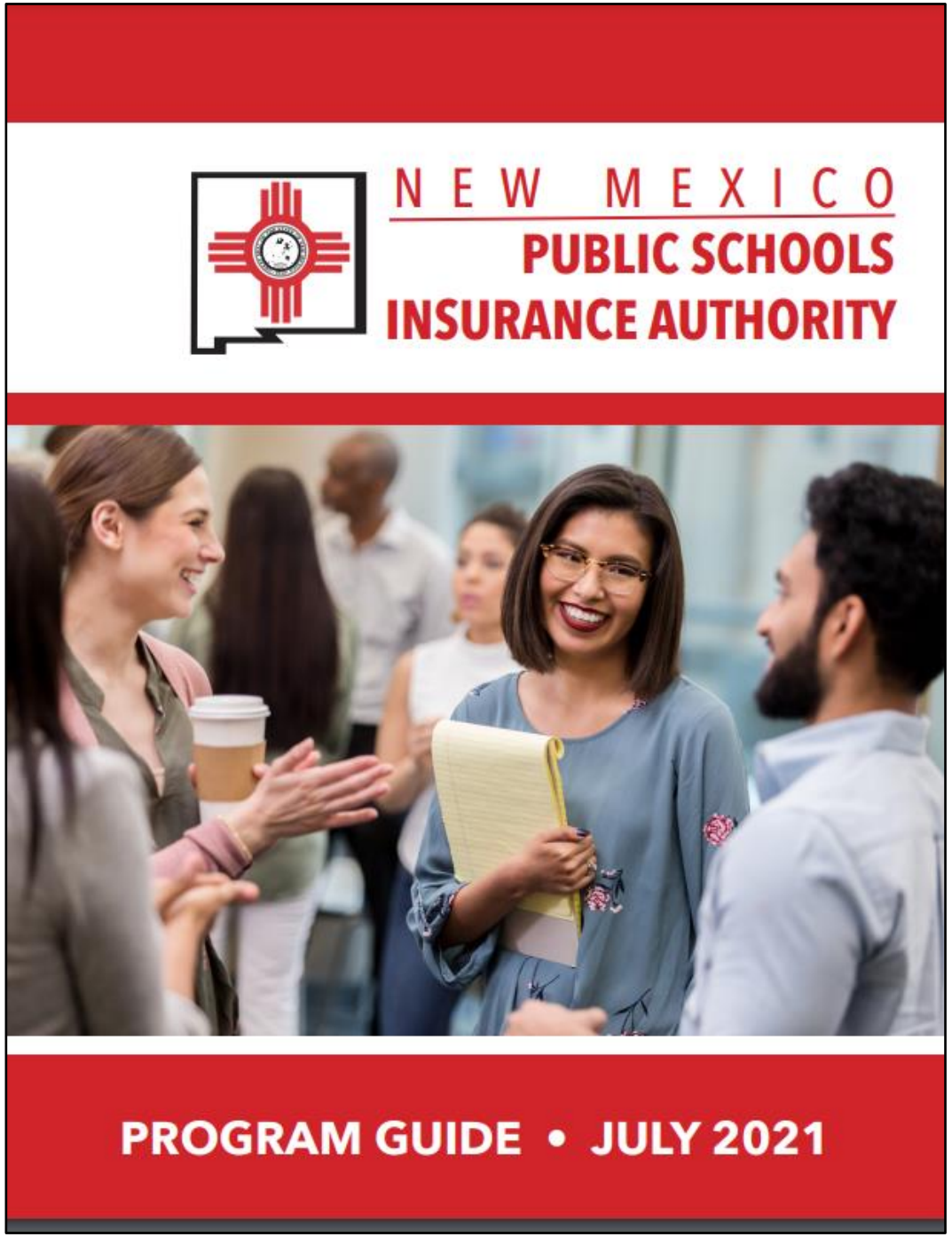
New Mexico Public Schools Insurance Authority

NMPSIA Website and Program Guide

Visit

https://nmpsia.com/

EASI
Erisa Administrative Services, Inc.



New Mexico Public Schools Insurance Authority

Glossary of Terms and Acronyms

EASI
Erisa Administrative Services, Inc.

Evidence of Insurability and Life Claims
Glossary of Terms and Acronyms

Acronym	Term	Definition
	2021 Change Card	Form used to report a Qualifying Event or change to an employees status or demographic information.
	Death Certificate	An official statement, signed by a physician, of the cause, date, and place of a person's death.
	Employee Enrollment Application	Form completed by both employee and employer when enrolling in NMPSIA medical, dental, vision and life benefits
	Funeral Assignment	An agreement that is signed by a beneficiary of a life insurance policy assigning all or a portion of the life insurance benefits at the funeral home which allows payment for funeral expenses to be made directly to the funeral home.
	Schedule A - Beneficiary Designation	Form completed by member assigning beneficiary(ies) for Basic and Additional Life Insurance benefits
	Underwriting	Life insurance underwriting is a process where insurance carriers assign applicants a classification based on several factors. Underwriters consider several rate factors such as your age, gender and medical history to evaluate risk.
	Proof of Death Claim Form	A document required to be completed by the NMPSIA participating employer's authorized representative upon notification of employee/dependent death and submitted to The Standard for review.
ADL	Additional Life	A NMPSIA benefit - 1X, 2X or 3X base annual earnings to a maximum of $500,000. Employee pays 100%
EE	Employee	NMPSIA participating Employee
ER	Employer	NMPSIA participating employer
EASI or Erisa	Erisa Administrative Services, Inc.	NMPSIA's Third Party Administrator who handles enrollment, eligibility, premium billing, premium collection and COBRA administration.
EOI	Evidence of Insurability	The application process in which you provide information on the condition of your health or your dependent's health to get certain types of insurance coverage.
FAQ	Frequently Asked Questions	Frequently Asked Questions
LTD	Long Term Disability	Long-term disability insurance is coverage intended to protect your income if you are unable to work due to illness or injury.
MHS	Medical History Statement	A statement or proof of a person's physical condition that is required to obtain certain types of insurance.
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.
SPLF	Spouse Life	A NMPSIA benefit - Spouse/Domestic Partner eligible for lesser of 50% of employee's coverage or 1X employee's base annual earnings. Employee pays 100%

New Mexico Public Schools Insurance Authority

Frequently Asked Questions (FAQ)

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

EASI
Erisa Administrative Services, Inc.

Evidence of Insurability and Life Claims
Employer Frequently Asked Questions

1. **To whom should a life claim be submitted?**
   All claim documents must be emailed by the employer's benefits representative to lifepro@standard.com with the Subject line: *"NMPSIA 645549 Life Claim for (Deceased's Name)".*

2. **Does a spouse/domestic partner applying for ADL, SPLF or LTD have to complete a separate Medical Health Statement?**
   Yes. If applying for a spouse, a separate MHS must be submitted for him/her.
   Note: Not applicable to children.

3. **Who can be named as beneficiary on a beneficiary designation form?**
   Any person may be named as a life insurance beneficiary.

4. **How often can a beneficiary be changed?**
   A member may change or update a beneficiary as often and at any time they like.

5. **When is Evidence of Insurability (EOI) required?**
   EOI is generally required for coverage in excess of any applicable guarantee-issue amount, late entrants, reinstatements if required, members and dependents eligible but not insured under the prior plan and reapplications of previously-declined coverage.

6. **How is the Evidence of Insurability(EOI)/Medical Health Statement (MHS) submitted?**
   Once completed, printed, signed and dated the EOI/MHS(s)* and Employee Change Card must be submitted to the employer who sends directly to Erisa Administrative Services.
   DO NOT submit any documents to The Standard. Erisa will submit to The Standard.

7. **Where can the Medical Health Statement (MHS) be found?**
   The Standard MHS can be located on the NMPSIA website at the following link:
   https://www.standard.com/eforms/16119_645549.pdf

8. **When is approved ADL, SPLF or LTD coverage effective?**
   The coverage effective date is determined by The Standard.

9. **Who completes the Proof of Death Claim Form?**
   This document and all life insurance claims, including dependent life insurance are required to be completed by the **NMPSIA participating employer's authorized representative.**

10. **Can ADL, SPLF or LTD be added during the NMPSIA Open Switch Enrollment period?**
    No. NMPSIA's Open/Switch Enrollment period is a designated time to ADD or CHANGE medical, dental and vision benefits only and **not the time to add or change life benefits**.

11. **When can ADL, SPLF or LTD be added?**
    The late enrollment process for ADL, SPLF and LTD applications can be submitted to Erisa at **ANY TIME** of the year.

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.

EASI
Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

Erisa

Kathy Payanes
Account Manager
kpayanes@easitpa.com

Chere Garcia
Benefits Representative
cgarcia@easitpa.com

Jackie Martinez
Benefits Representative
jmartinez@easitpa.com

Michelle Aragon
Benefits Representative/
Administrative Assistant
maragon@easitpa.com

Lourdes Rael
Operations Supervisor
raell@easitpa.com

EASI
Erisa Administrative Services, Inc.

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

New Mexico Public Schools Insurance Authority

The Standard

Greg Archuleta

Account Specialist On-Site-IBAC

The Standard

Standard Insurance Company

Office Phone: 971.321.0957 Cell: 505.205.4794

Gregory.Archuleta@standard.com

www.standard.com

Group Number: 645549

1.888.609.9763 Ext. 0957

LifePro@Standard.com

EASI

Erisa Administrative Services, Inc.

New Mexico Public Schools Insurance Authority

A review of today's session

- ✓ Defined EOI and Life Claims
- ✓ Reviewed the process of submitting both an EOI and Life Claim
- ✓ Reviewed the various documents that must be submitted for both an EOI and Life Claim
- ✓ Outlined the numerous resources available

EASI
Erisa Administrative Services, Inc.