Benefit Services
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Las Cruces, NM 88003-8001
Phone: (575) 646-8000
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benefits@nmsu.edu

Blue Cross and Blue Shield of New Mexico

Enrollment Application / Change Form – Dental and Vision

New Mexico State University **Account #265001** Group # Dental 268431 **Account #26500** Group # Vision: GFZ02001	0001 0002 0003 9902	Non Medicare Non Medicare Surviving Deps Medicare <70 COBRA Admin	0004 0005 0101	Medicare Surviving Deps Medicare 70+ Dental-No Medical Coverage

Section 1 – Enrollment Event

☒ Open Enrollment
Effective Date of Benefits: **01/01/2023**

☐ New Enrollee ☐ Add Dependent

Cancel coverage: ☐ Dental ☐ Vision

☐ Cancel Enrollee (& Dependents)
☐ Cancel Dependent
Please note: If you terminate coverage you MAY NOT re-enroll until after a 4-year waiting period and only during open enrollment.

Section 2 – Please tell us about yourself

Name (Last)	(First)	(MI)	Date of Birth	Aggie ID #	
Mailing Address (Street)	(City)	(State) (Zip Code)	Phone	Social Security #	Sex ☒ Female ☐ Male

Dental Coverage	**Who is covered? (select one)**	**Vision Coverage**	**Who is covered? (select one)**
☐ Yes ☐ No	☐ Retiree only ☐ Retiree + Spouse/DP ☐ Retiree + Child (ren) ☐ Retiree + Family	☐ Yes ☐ No	☐ Retiree only ☐ Retiree + One ☐ Retiree + Family

Dependents:

☐ **Husband** ☐ **Wife**	**Dependent Name:**	☐ **Male** ☐ **Female**
☐ **Domestic Partner**	**Dependent SSN:**	**Birthdate: (mm/dd/yyyy)**
☐ **Son** ☐ **Daughter**	**Dependent Name:**	☐ **Male** ☐ **Female**
☐ **Other Dependent**	**Dependent SSN:**	**Birthdate: (mm/dd/yyyy)**
☐ **Son** ☐ **Daughter**	**Dependent Name:**	☐ **Male** ☐ **Female**
☐ **Other Dependent**	**Dependent SSN:**	**Birthdate: (mm/dd/yyyy)**
☐ **Son** ☐ **Daughter**	**Dependent Name:**	☐ **Male** ☐ **Female**
☐ **Other Dependent**	**Dependent SSN:**	**Birthdate: (mm/dd/yyyy)**

- **I am an employee of the employer or a retiree named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is underwritten or administered by Blue Cross and Blue Shield of New Mexico. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct.**
- **I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).**
- **Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).**
- **I agree that my employer acts as my agent. I authorize necessary payroll deductions by my employer, if any, to cover the cost of my coverage(s).**
- **I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.**

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

Applicant's Signature	Date: