Benefit Services
Hadley Hall, Room 17
MSC 3HRS, PO Box 30001
Las Cruces, NM 88003-8001
Phone: (575) 646-8000
Fax: (575) 646-2806
benefits@nmsu.edu

Benefit Enrollment/Waiver Form

Medical, Dental, Vision, Life, & Disability Insurances

Refer to Administrative Rules and Procedures (ARP) Chapter 8 and benefits.nmsu.edu/ for information regarding the benefits offered through NMSU, including eligibility, premium rates, forms, carrier contacts, etc.

Employee Eligibility: To be eligible for coverage you must be hired as regular faculty, regular staff, term faculty, or term staff at .75 FTE or greater (see ARP 6.03-Employment Categories).

Employees who are also the spouse, domestic partner, or dependent of an employee of NMSU, State of New Mexico, or any other entity participating in the State of New Mexico's medical and dental programs, may be covered as either an Employee or Dependent, but not both. Dual coverage is not permitted for you or your dependents.

Dependent Eligibility: To be eligible for coverage your dependent must be one of the following:

- Your lawful spouse or qualified Domestic Partner (DP)
  - A spouse or DP that is also an NMSU employee must check "Yes" on Section 3 of the form and include their Aggie ID number.
  - DP information can be found at http://benefits.nmsu.edu/other/domestic-partner/. Insurance premiums for DPs are not eligible for pre-tax premiums, and the value of tuition and insurance benefits provided to the DP is considered taxable income to the employee by the Internal Revenue Service and is subject to social security, federal, and state income tax withholding. You are advised to consult an attorney and/or tax consultant prior to establishing a DP.
- Your biological or adopted child, or the biological or adopted child of your spouse or DP, under the age of 26.
  - All children of a domestic partner, who are not biological or adopted children of the employee, must be designated on the enrollment form by checking "Domestic Partner's child". Do not check this box if the child is the employee's biological or adopted child.
- Your child defined above that is financially dependent due to a permanent mental or physical disability occurring prior to age 26. A physician's certification of disability is required.

Documentation supporting the relationship and eligibility of all dependents must be submitted with the enrollment form. Acceptable documents are listed at https://benefits.nmsu.edu/enrollment/eligibility.html#dependent.

List dependents that may use the tuition waiver benefits on the enrollment form and provide dependent eligibility documentation, even if you do not enroll them in any insurance benefits. Complete an online tuition waiver request each applicable semester.

It is your responsibility to remove any dependents who do not meet the eligibility requirements within 31 days of the disqualifying event. Failure to do so may result in losing the ability to participate in any health benefits offered by NMSU, as well as a responsibility to repay all claims paid out on behalf of the ineligible dependent.

Deadlines: All Benefit Enrollment/Waiver forms and supporting documentation must be **received** by Benefit Services within 31 calendar days of the date of hire or qualifying event. Complete forms electronically or ensure print is legible. Incomplete or illegible forms will be returned to the employee for completion and must be re-submitted by the deadline. Only enrollments received by the deadline will be processed. Retain a copy and proof of submission for your records.

- **New Employees/Newly Benefit Eligible Employees**: this form and dependent documentation are due no later than your 31st calendar day of employment in a benefit-eligible position.
- **Qualifying Events:** this form, documentation supporting the qualifying event, and dependent documentation are due within 31 calendar days of the event. Qualifying events information is available at https://benefits.nmsu.edu/enrollment/change.html. If applicable, payroll deductions will be adjusted for retroactive coverage.

If required forms and documentation are not received by the deadline, the employee and/or dependent(s) will not be added to coverage. The next opportunity for enrollment will then be at the next Open Enrollment or qualifying event. Open Enrollment applies to Medical, Dental, Vision, and Flexible Spending Account benefits. Late enrollment may be available for other benefits and may have additional restrictions.

Note for 9-month faculty and 9-month staff: premiums are collected over the academic year (August-May) for fiscal year (July 1-June 30) coverage.

The State's Group Benefits Plan privacy notice is posted https://www.mybenefitsnm.com/Documents/HIPAA_Policies_and_Procedures_RMD.pdf. NMSU's HIPAA Privacy Notice is available at https://benefits.nmsu.edu/insurance/hipaa.html. Creditable Coverage Notice is available at https://www.mybenefitsnm.com/FGPOpenFPN.html.

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Benefit Enrollment/Waiver Form

Medical, Dental, Vision, Life, & Disability Insurances

1. Employee Information

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

2. Type of Enrollment/Waiver

☐ **New Hire**
Date of hire: __________
☐ **Newly Benefit Eligible**
Date of current hire: __________
☐ **Late Enrollment**

☐ **Change in Status/Qualifying Event** – Supporting documentation required

Date of Change in Status / Qualifying Event: __________

☐ Birth/Adoption ☐ Marriage ☐ Divorce
☐ Change in eligibility status ☐ Gain of other Coverage ☐ Loss of other Coverage
☐ Death ☐ Other: __________

3. Dependent Information – Supporting documentation required https://benefits.nmsu.edu/enrollment/eligibility/ - dependent

Type	Dependent	Sex	Social Security#	Date of Birth (MM/DD/YYYY)	Action	Coverage
☐Spouse ☐Domestic Partner (DP)	Last, First MI__________ , __________ _____ NMSU employee? ☐ Yes ☐No Aggie ID __________	☐ Female ☐ Male	SS# DOB:		☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐AD&D
☐Child ☐Domestic Partner's child	Last, First MI__________ , __________ _____ Aggie ID __________	☐ Female ☐ Male	SS# DOB:		☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ AD&D
☐Child ☐Domestic Partner's child	Last, First MI__________ , __________ _____ Aggie ID __________	☐ Female ☐ Male	SS# DOB:		☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ AD&D
☐Child ☐Domestic Partner's child	Last, First MI__________ , __________ _____ Aggie ID __________	☐ Female ☐ Male	SS# DOB:		☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ AD&D
☐Child ☐Domestic Partner's child	Last, First MI__________ , __________ _____ Aggie ID __________	☐ Female ☐ Male	SS# DOB:		☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ AD&D

4. Medical/Pharmacy Plan

☐New ☐Cancel ☐Change ☐No Change

☐ Presbyterian HMO
☐ BlueCross BlueShield of NM HMO
☐ BlueCross BlueShield of NM PPO
☐ Cigna OAPIN (HMO)
☐ Cigna OAP (PPO)
- ☐ Employee (EE) Only
- ☐ EE + Spouse / DP
- ☐ EE + Child(ren) *[No Spouse/DP]*
- ☐ Family *[EE, Spouse/DP + child(ren)]*

☐ **Decline Medical/Pharmacy Coverage**

5. Dental Plan

☐New ☐Cancel ☐Change ☐No Change

☐ Delta Dental
- ☐ Employee (EE) Only
- ☐ EE + Spouse / DP
- ☐ EE + Child(ren) *[No Spouse/DP]*
- ☐ Family *[EE, Spouse/DP + child(ren)]*

☐ **Decline Dental Coverage**

6. Vision Plan

☐New ☐Late ☐Cancel ☐Change ☐No Change

☐ Vision Service Plan (VSP)
- ☐ Employee (EE) Only
- ☐ EE + Spouse / DP
- ☐ EE + Child(ren) *[No Spouse/DP]*
- ☐ Family *[EE, Spouse/DP + child(ren)]*

☐ **Decline Vision Coverage**

7. NMSU Pre-Tax Premium Plan for Medical, Dental, & Vision Plans

Except for an allowable Change in Status event, I understand that I cannot change my elections until the next Open Enrollment. I understand that the tax implications for the pre-tax program are regulated by the IRS and I hold NMSU harmless if any damages or losses occur to me.

☐ **YES, I ELECT** and authorize NMSU to reduce my salary in the amount necessary to make my contributions toward payment of premiums for the applicable plans with "pre-tax" dollars. __________ **(Initials)**

☐ **NO, I DECLINE** the NMSU Pre-Tax Premium Plan and elect to pay for the plans on an after-tax basis. __________ **(Initials)**

Employee Name (Last, First MI)	Aggie ID#

8. Group Life & AD&D Insurance

☐ New ☐ Late Enroll ☐Cancel ☐ No Change

☐ **I DECLINE Group Life & AD&D Insurance.** I understand that if I choose to enroll at a later date, a health questionnaire will be required.
_____ **(Initials)**

☐ **I ELECT** Dearborn National® **Group Life & AD&D**

- Coverage is equal to 2 times basic annual earnings rounded to next $1,000, maximum of $75,000. Employee contribution is based on salary.
- Earnings do not include overtime, bonuses, or any other form of extra pay. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to active work.

_____ **(Initials)**

9. Long-Term Disability Insurance

☐ New ☐ Late Enroll ☐Cancel ☐ No Change

☐ **I DECLINE Long-Term Disability Insurance.** I understand that if I choose to enroll at a later date, a health questionnaire will be required.
_____ **(Initials)**

☐ **I ELECT** Dearborn National® **Long-Term Disability**

- I hereby request to be insured and authorize NMSU to deduct the amount I am required to pay for my share of the cost of the benefit to which I am entitled under the group policy issued to NMSU. I understand that if I am not actively at work on the effective day of coverage, my insurance will not begin until the day I return to active work.

_____ **(Initials)**

10. Voluntary Life & AD&D Insurance

☐ New Enrollment ☐ Late Enroll ☐Cancel ☐ Change ☐ No Change

☐ **I DECLINE Voluntary Life AND Accidental Death & Dismemberment Insurance.**
I understand that if I choose to enroll at a later date, a health questionnaire will be required. _____ **(Initials)**

☐ **I ELECT** Dearborn National® **Voluntary Life AND Accidental Death & Dismemberment**

- Guaranteed Coverage: Employees must enroll within 31 days of their eligibility date to qualify for any established guaranteed coverage amounts. Evidence of Insurability is required for late applicants and amounts exceeding the Guarantee Issue limits.
- I hereby request to be insured and authorize NMSU to deduct the amount I am required to pay for my share of the cost of the benefit to which I am entitled under the group policy issued to NMSU. I understand that if I am not actively at work on the effective day of coverage, my insurance will not begin until the day I return to active work.

_____ **(Initials)**

10a. Voluntary Life Requested Coverage (minimum $20,000 to maximum $600,000 in $10,000 increments) check all that apply:

☐ **Employee Guaranteed Coverage** (up to $200,000): $ _____

☐ Employee Additional Coverage (total employee coverage cannot exceed $600,000): $ _____

☐ **Spouse/DP Guaranteed Coverage** (up to $50,000 – cannot exceed Employee Amount): $ _____

☐ Spouse/DP Additional Coverage (total cannot exceed the lesser of Employee Amount or $100,000): $ _____

☐ **Child(ren) Coverage**: ☐ Option 1- $1,000 <6mos/$5,000 6mos. +
☐ Option 2- $2,000 <6mos/$10,000 6mos. +

10b. Accidental Death & Dismemberment (between $20,000 and $150,000 in $10,000 increments or $200,000 or $250,000):

☐ Individual ☐ Family
Amount of Election: $ _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or false information in an insurance application is guilty of a crime and may be subject to civil fines and criminal penalties.

11. Employee Authorization & Signature

I certify that all information supplied on this form is true to the best of my knowledge. I understand that all benefits for me and my eligible dependents will be provided in accordance with the terms of the plan(s) in which I have enrolled. I agree to abide by the terms and conditions provided in the plan(s) and authorize any hospital, physician, dentist, or other health care provider to furnish medical information regarding me and my dependents necessary to process claims. I authorize the carrier(s) to coordinate benefits and/or reimbursements with other health or dental plans or insurance companies.

I authorize NMSU to make any necessary deductions from my pay through payroll deduction. I understand that it is my responsibility to review my semi-monthly pay advice to ensure deductions are accurate, and I must contact Benefit Services immediately if the deductions are not accurate.

Employee Signature: _____ **Date:** _____

HR Use Only	Medical/Rx	Dental	Vision	Group Life	LTD	Vol. Life	AD&D
Code:							
DEDN Date:							
BCOV Date:							
Benefits Notes:							
Payroll Notes:							

dearborn national®

Underwritten by Dearborn National® Life Insurance Company

BENEFICIARY DESIGNATION FORM

INSTRUCTIONS (PLEASE PRINT, SIGN, AND DATE THIS FORM IN BLACK INK)			
Employee/Retired Employee Name (Last, First MI) ,	Social Security #	Date of Birth	Home Telephone Number
Home Address	City	State	Zip
Employer **New Mexico State University (NMSU)**		Group Number **GFZ02001**	

DEFINITIONS & STATEMENTS

Primary Beneficiary means the person or persons who will receive the benefits in the event of the Insured's death. Proceeds will be divided in equal shares if multiple primary beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%.

Contingent Beneficiary means the person or persons who will receive the benefits if the primary beneficiary is not living at the time of the Insured's death.

Will or Trust as Beneficiary Designation can be done by using the following written statement: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]." If you wish to designate a testamentary trust as beneficiary (i.e. created by will), you should recognize the possibility that your will, which was intended to create a trust, may not be admitted to probate (because it is lost, contested, or suspended by a later will). Claim payment delays can result if the beneficiary designation does not provide for this situation. **

Minors as Beneficiary Designation can be done by using this document. However, please note if your beneficiary is a minor at the time of claim, payments may be delayed due to special issues raised by these designations. **

Dependent Beneficiary – In the event a dependent dies, the employee is the beneficiary of their life insurance proceeds.

**You may want to obtain the assistance of an attorney to help consider any special circumstances before drafting your beneficiary designation.

BENEFICIARY DESIGNATION FOR ALL EMPLOYEE/RETIRED EMPLOYEE LIFE BENEFITS

Primary Beneficiary	**Birth Date**	**Relationship**	**Social Security #**	**Address**	**%**
Contingent Beneficiary	**Birth Date**	**Relationship**	**Social Security #**	**Address**	**%**

WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

Employee/Retired Employee Signature_____ **Date**_____

Important Note for Married Employees: If you live in a community property state/territory, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states/territories currently include: AZ, CA, GU, ID, LA, NM, NV, PR, TX, WA, and WI. Payment of benefits may be delayed or disputed unless your spouse consents to waive their rights to any community property interest in the benefits. Below we have provided a "Spousal Consent for Community Property States" for your spouse's signature. **DEARBORN NATIONAL® LIFE INSURANCE COMPANY (DEARBORN NATIONAL) WILL NOT BE LIABLE FOR DAMAGES DUE TO ANY DELAY OR DISPUTE IN PAYMENT OF BENEFITS IF YOU CHOOSE NOT TO OBTAIN YOUR SPOUSE'S SIGNATURE.**

Spousal Consent for Community Property States/Territories: I hereby consent to the Primary Beneficiary designated by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature_____ Date_____ ☐ Employee has no legal spouse