

CHANGE REQUEST FORM



4308 Carlisle Blvd. NE, Suite 104
 Albuquerque, NM 87107
 1 (800) 233-2576 • (505) 222-6400 • Fax: (505) 884-8611

Please see instruction sheet attached and PRINT CLEARLY.

A Retiree Personal Information — Complete ALL blanks in this section.

| | | | | |
|------------------------------------|---|-----------------|--------------------|-------------------------------|
| 1. Social Security No. | 2. PRINT Last Name | First Name | MI | 3. Date of Birth (MM/DD/YYYY) |
| 4. E-Mail Address | 5. Mailing Address — <i>If new, check box in Section B-1</i> | | | |
| 6. Effective Date of Change | b. City | c. State | d. ZIP Code | e. Home Phone () |

B Change Personal Information

1. CHANGE **ADDRESS**: *Write new address & phone no. in Section 4*

2. CHANGE **NAME**: a. *Write new name in Section A-2*
 b. *Write former name here:*

C Change Level of Coverage (Each enrollee's level of coverage must be the same; unless one party is Medicare eligible (single, two party or family); spouse/dependents will default to retiree's selection).

1. **NEW LEVEL OF COVERAGE REQUESTED:** Single Two-Party Family

2. **ADD DEPENDENT(S)/DOMESTIC PARTNER: List in #4 below**

a. Marriage date: ___/___/___ (attach certificate) c. Newly eligible (attach supporting documents)
 b. Newborn birth date: ___/___/___ (attach certificate) d. Approve through Health Statement (attach)

3. **NEW DEPENDENTS**

| a. Soc. Sec. # | b. Full name | c. Date of birth (MM/DD/YYYY) | d. Sex | e. Relationship | f. Medicare | |
|----------------|--------------|----------------------------------|---|-----------------|---|---|
| | | | | | Part A | Part B |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |

4. Select plan for new dependents:

| | | |
|---------------------------|------------------------------|--|
| Non-Medicare Plans | Name _____ Name _____ | <p>Choose one plan for all non-Medicare members (Out-of-state non-Medicare enrollees must select BCBS Premier)</p> <input type="checkbox"/> BCBS Premier PPO <input type="checkbox"/> Presbyterian Premier PPO <input type="checkbox"/> NM Health Connections Value HMO <input type="checkbox"/> Presbyterian Value HMO <input type="checkbox"/> BCBS Value HMO |
|---------------------------|------------------------------|--|

| | | |
|---|--|---|
| Medicare Plans ¹ <small>(For applicants eligible for Medicare benefits)</small> | <input type="checkbox"/> BCBSNM Medicare Supplemental Plan <input type="checkbox"/> BCBS Advantage Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> Presbyterian Advantage Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> United Healthcare Advantage Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> Humana Advantage Plan I <input type="checkbox"/> Plan II | <ul style="list-style-type: none"> Medicare Parts A and B are required for all Medicare Plans. Please provide a copy of the Medicare card or Entitlement letter if Medicare card is in process. |
| <p>IMPORTANT: Out-of-state enrollees must select the BCBSNM Supplemental or United Healthcare or Humana Medicare plan. ¹Service area for Presbyterian and BCBS Advantage Plans are limited to the State of New Mexico</p> | | |

5. Will anyone listed on this form be covered by any other health insurance, government program, or HMO (besides Medicare listed in #4 above) while *also* enrolled in the NMRHCA? Yes No **IF YES:**

| Full name | Employer | Insurance company | Policyholder? | Policy date | Type |
|-----------|----------|-------------------|--|-------------|---|
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Group <input type="checkbox"/> Private |

6. **Dental and Vision Coverage** – Note: Any dental and vision changes must be done during the annual switch enrollment period. This option is just for new dependents.

| | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Delta Dental Comprehensive | <input type="checkbox"/> Delta Dental Basic | <input type="checkbox"/> Davis Vision |
| <input type="checkbox"/> United Concordia Comprehensive | <input type="checkbox"/> United Concordia Basic | |

D Cancel Coverage

Note: Monthly deduction will continue unless written notification to cancel is made one month in advance. Effective date of cancellation is not retroactive.

| Retiree | Spouse/Domestic Partner | Dependent |
|--|--|--|
| <input type="checkbox"/> Cancel my medical plan ¹ <input type="checkbox"/> Cancel my dental plan ² <input type="checkbox"/> Cancel my vision plan ² <input type="checkbox"/> Cancel my Supplemental Life plan <input type="checkbox"/> Cancel <u>all</u> benefit plans for all members ¹ | <input type="checkbox"/> Cancel medical plan <input type="checkbox"/> Cancel dental plan ² <input type="checkbox"/> Cancel vision plan ² <input type="checkbox"/> Cancel Supplemental Life plan | <input type="checkbox"/> Cancel medical plan <input type="checkbox"/> Cancel dental plan ² <input type="checkbox"/> Cancel vision plan ² <input type="checkbox"/> Cancel Supplemental Life plan |
| | Name: _____ | Name: _____ Name: _____ |

¹If you have been grandfathered into the \$6,000 Basic Term Life and AD&D insurance coverage's will also be cancelled. ²If you drop dental or vision coverage for any reason, you must wait four years before enrolling again.

E Change Amount of Life Insurance**E. Change Amount of Life Insurance** **Decrease coverage:**

Retiree \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000
Spouse \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000
Child \$2,500 \$5,000

 Increase* coverage:

Retiree \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000 \$60,000
Spouse \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000 \$60,000
Child \$5,000 \$10,000

Losing Retiree Life coverage from New Mexico Public Schools Insurance Authority (NMPSIA) due to age:

With proof of life insurance amounts lost from NMPSIA and enrolling within 31 days of the loss you may enroll up to the insurance amounts lost.

Retiree \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000 \$60,000
Spouse \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000 \$60,000
Child \$2,500 \$5,000 \$10,000

 Add* coverage:

Retiree \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000 \$60,000
Spouse \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$15,000 \$20,000 \$40,000 \$46,000 \$60,000
Child \$2,500 \$5,000 \$10,000

Note: *Increasing or adding coverage is not allowed for a Survivor member; An Evidence of Insurability Statement is required for Retiree and Spouse to Increase or Add coverage. (Please call 1-800-233-2576 to request an Evidence of Insurability Statement); Spouse and Child coverage amounts may not exceed Retiree coverage amount.

F Change Method of Premium Payment / Retiree Authorization for Deduction
(ERB retirees are required to select option 2, automatic bank draft)

- I hereby authorize a deduction from my pension earnings for NMRHCA insurance plan contributions.
- I hereby authorize an automatic bank draft on my checking account for NMRHCA insurance plan contributions.
IMPORTANT: PLEASE ATTACH A VOIDED CHECK IF CHOOSING BANK DRAFT.
MONTHLY DEDUCTION WILL CONTINUE UNLESS WRITTEN NOTIFICATION TO CANCEL IS MADE ONE MONTH IN ADVANCE.

G DECLARATION AND SIGNATURE

I hereby declare the information I have provided above is true and complete to the best of my knowledge. I further declare that I have read carefully and understand the statements on the reverse side of this form and that I make the authorizations declared under Section G. (If signing under power of attorney, please attach authorizing documents if not already on file with NMRHCA.)

Signature _____ Date _____

Spouse Signature _____ Date _____

CHANGE REQUEST FORM INSTRUCTIONS

Section A

Complete entire section, giving *current* data for retiree (or surviving eligible dependent if retiree is deceased). *Effective Date of Change (#6)*: Changes will take effect on the 1st of the month following the qualifying event, except in the case of a newborn or adopted dependent (coverage's will take effect on the 1st of the month of the birth day or adoption). You must submit this Change Request Form within 31 days of the qualifying event.

Section B

*Complete only if you wish to **change** your address (#1) or name (#2).*

Section C

- Complete only if you wish to **change** your level of coverage.* Indicate change in #2 or #3.
- Complete only if you wish to **add** dependents.* See NMRHCA *Summary of Benefits* or call NMRHCA for definition of eligible dependents. If you add dependent(s) after your initial enrollment, you must attach a loss of coverage letter for each dependent to be added, unless dependent is *newly* eligible (marriage, birth, *involuntarily* termination of health care coverage under another program—see *Summary of Benefits*). Documentation of event causing new eligibility is required (copy of marriage certificate, birth certificate, court decree of adoption or legal guardianship, etc.). The appropriate premium (check or money order) for the new dependent(s) must also be included with this form.
- Complete entire section if you are **adding** (#2) dependents.* Attach additional sheet if you are adding more than two dependents.
- Select a medical plan for your new dependent(s). **Medicare dependents:** Be sure to submit a copy of a Medicare card showing Parts A and B. Even though Medicare allows you to reject Part B, you are **required** to purchase it in order to enroll in certain NMRHCA Medicare Plans. If you and/or your dependents are Medicare-eligible but do not carry Medicare Part A and/or Part B, see Summary of Benefits or call the NMRHCA to learn about the consequences. **Non-Medicare:** all out of state non-Medicare enrollees must choose the BCBS Premier option.
- Complete only if your coverage has **changed** or if you are **adding** (#2) dependents.*

Section D

*Complete only if you wish to **cancel** coverage.* If you cancel your medical coverage and you have enrolled with Medical benefits prior to January 1, 2012, we will also cancel the \$6,000 Basic Term Life and AD&D insurance automatically. Future reapplication for NMRHCA medical plan coverage may require submission of a Loss of Coverage letter for retiree and any dependents to be covered. If you cancel only dental or vision coverage, you must wait four years before enrolling again during the subsequent Switch Enrollment Period. If you cancel only retiree and/or dependent additional life, future reapplication will require submission of an Evidence of Insurability Statement for each individual to be covered by additional life insurance.

Section E

*Complete only if you wish to **change** the amount of your life insurance coverage (**decrease** amount in #1, **increase** amount in #2 or #3; or **add** that line of coverage for the first time in #4).* If you wish to **increase or add** life insurance for the retiree and/or dependents, you **must submit an Evidence of Insurability Statement for each enrolled individual affected**. It may take up to two (2) months for determination. You need not submit an Evidence of Insurability Statement to decrease or cancel life insurance for the retiree and/or dependents.

Section F

*Complete only if you wish to **change** your method of paying your NMRHCA premium contributions.* If you do not change it, adjustments will automatically be made in your *current* method of payment to reflect any changes you make in your coverage. ERB retirees are required to select option 2, automatic bank draft.

Section G

You MUST sign and date this form. Send original to NMRHCA, 4308 Carlisle Blvd. NE, Suite 104, Albuquerque NM 87107; keep a copy for your records.

DECLARATION (please read before signing): I understand that my submission of this application does not constitute acceptance by the NMRHCA and that service will be available subject to the exclusions, limitations, and conditions described in the Retiree Health Care Act, the insurance carrier Benefit Booklets, and the Group Policy Certificate. I understand my premiums may be adjusted to reflect the changes I have requested on this form and that they may be adjusted from time to time, and I authorize that adjustment in my pension deduction or bank draft. I understand that I may be direct-billed and should pay the billed amount directly until any change in my deduction or draft amount is processed. I authorize my insurance carriers to coordinate benefits and/or reimbursements with other health plans or insurance carriers. I authorize my medical insurance carrier to obtain information from the Social Security Administration regarding my and my dependents' Medicare eligibility. I authorize any health care provider to furnish, when applicable, medical information regarding me and my dependents.

If you have questions about the information contained or requested in this form, please contact the NMRHCA at
1-800-233-2576, Fax: 505-884-8611

www.nmrhca.org