IMPORTANT NOTICES

DEADLINE FOR APPLICATION

It is best to submit your application and the applicable documents listed below at least **one month but not to exceed 60 days** prior to your last date of coverage to allow adequate time for the agency to process your application. **Please be advised it takes a minimum of 3 business weeks for an application to be processed.***

Please note: All Medicare enrollee applications must be submitted prior to the effective date of enrollment.

Early application is encouraged to help you avoid a possible lapse in your health care coverage and to assist our carriers in providing you with your insurance ID cards and important information prior to your effective date.

APPLICATION CHECKLIST

Do NOT staple or tape any documents to the forms.
Photos of documents will not be accepted.

1. General Enrollment Application *(Please verify your last date of coverage with your employer or your spouse's employer prior to completing)*
2. Work History Form *(NMRHCA-participating employers only. Employer list located on back of form)*
3. Standard Initial Life Insurance Enrollment Form *(if applying for Life Insurance through the New Mexico Retiree Health Care Authority)* **If you are enrolling more than 31 days after retirement underwriting approval for Life Insurance is required.**
4. First Premium Payment Worksheet
5. First premium payment *(2 months)*. **Payable to NMRHCA** (*Check or money order only*)
6. Copy of Marriage Certificate/License (*If enrolling a Spouse with any benefits*)
7. Copy of Children's Birth Certificates (*If enrolling children*)
8. Copy of Medicare Card (*If applicable*)
9. PERA/ERB *(Certified evidence of total years of service from pension system)*
10. Loss of Coverage letter if enrolling 31 days after retirement date or last date of coverage. (*If you have had a lapse in coverage of over 31 days you will need to wait until Open Enrollment. Please call 1-800-233-2576 for more information.)*

RETIREE ELIGIBILITY

You are an "eligible retiree" (eligible to participate in the NMRHCA) if you receive a disability or normal retirement benefit from public service in New Mexico with an NMRHCA-participating employer (shown on the back of the Work History Form), *AND*

(Please See Other Side)

- You retired with a pension before your employer's effective date with the NMRHCA program,

or

- You and/or your employer (on your behalf) made contributions to the NMRHCA fund from your employer's NMRHCA effective date until your date of retirement,

or

- You and/or your employer (on your behalf) made contributions to the NMRHCA fund for at least five years before your date of retirement.

SPOUSE ELIGIBILITY

If you are enrolling a spouse who also qualifies as an eligible NMRHCA retiree, please call our office for an additional Work History Form.

REGARDING MEDICARE ELIGIBILITY

You, your spouse, and/or your dependent(s) may be eligible for Medicare Part A, if you, your spouse, and/or your dependent(s) are age 65 or older or receive Social Security Disability or Railroad Retirement benefits.

If you are eligible for Medicare Part A (Hospital), you must also apply for Medicare Part B (Medical). If you do not purchase Medicare Part B, you will be responsible to pay 100% of those charges.

Even though Medicare allows you to reject Part B, you are *required* to carry Parts A and B in order to enroll in all NMRHCA Medicare plans.

All NMRHCA Medicare Medical Plans include Part D (prescription) coverage.

To determine whether you have Part A and/or B, look at your Medicare card. It shows the Medicare coverage you have: Hospital Insurance (Part A), Medical (Physician) Insurance (Part B), or both. For information on how to enroll into Medicare, please call the Social Security Administration at 1-800-772-1213 or your local Social Security office.

Please call our office at 1-800-233-2576 if you are Medicare eligible and do not have Part A and/or Part B.

*If necessary the items listed in the Application Checklist can be submitted **within *31 days* after your retirement date or last day of insurance coverage** through your employer however, it is strongly advised that the application be submitted between 30 to 60 days prior to enrollment.

GENERAL ENROLLMENT APPLICATION

6300 Jefferson St NE, Suite 150
Albuquerque, NM 87109
1 (800) 233-2576 • (505) 222-6400 • (505) 884-8611 fax

Please read instructions before completing and PRINT CLEARLY.
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.

A Personal Information – Complete ALL blanks in this section.

Social Security No.	Last Name	First Name		Middle Initial
Mailing Address		City	State	Zip Code
Physical Address (Only if different from above)		City	State	Zip Code

Home Phone ( ) / Mobile Phone ( )	Date of Birth (MM/DD/YYYY)	E-mail Address	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Dom. Partner ☐ Divorced

B Classification of Applicant

☐ Retiree	☐ Surviving Spouse/Dependent of: Deceased Retiree's Name: ____________ Deceased Retiree's Social Security No.: ____________ Date of Death: ____________	☐ Other: ____________

C Employment/Retirement Information

1.Retirement Date: ____________ *Not necessarily last day of work.* 2. Employer at time of retirement:	3.Last date of insurance coverage through your employer or spouse **(required)**:	4. Pension System ☐ ERB (Education System) ☐ PERA (State, City, County) ☐ Other: ____________

D Level of Coverage Requested

☐ Single	☐ Two-Party (Complete Section E below)	☐ Family (Complete Section E below)

E Dependents to Be Covered

	Social Sec. #	Full Name	Date of Birth (MM/DD/YYYY)	Sex	Relationship to Retiree
Spouse*				☐ M ☐ F	
Domestic Partner				☐ M ☐ F	
Dependent 1				☐ M ☐ F	
Dependent 2				☐ M ☐ F	

*Does your spouse qualify as an eligible NMRHCA retiree? ☐ YES ☐ NO *If Yes* ⇨	…give his/her retirement date: ________ and last employer: ____________	…and does he/she receive a pension? ☐ YES ☐ NO

If your spouse qualifies as an eligible NMRHCA retiree and wishes to enroll separately, call the NMRHCA and request a General Enrollment Packet. If your spouse qualifies as an eligible NMRHCA retiree and has the same number of credible service years as you, then they may enroll under the same application, but an additional work history form is required by your spouse.

F Other Medical Insurance

Will anyone listed on this application be covered under any other health insurance, government program, or HMO (besides Medicare) while enrolled in the NM Retiree Health Care Authority? ☐ YES ☐ NO **IF YES:**

1. Full Name	2. Employer	3. Insurance Co.	4. Policyholder?	5. Policy Date	6. Type
			☐ YES ☐ NO		☐ Group ☐ Private

G Disability Information

Were you OR your spouse/dependent(s) disabled at the time of your retirement? ☐ NO ☐ YES-Retiree ☐ YES-Dependent
Was your retirement a result of a duty-related disability? ☐ NO ☐ YES-Retiree

Full Name	Disabling Condition	Have you applied for Disability Insurance (Medicare) through the Social Security Administration? ☐ YES ☐ NO	☐ Approved effective ___/___/___ ☐ Denied ☐ Notice not yet received

H 1. **MEDICAL Coverage** *(Each enrollee's level of coverage must be the same; unless one party is Medicare eligible. Out-of-state non-Medicare enrollees must select the BCBS Premier plan.) * If you do not enroll in medical coverage within 31 days of initial eligibility you must wait for the next subsequent Open Enrollment period (January 1st to January 31st of every odd numbered year with coverage effective January 1st) to re-enroll unless an involuntary loss of coverage due to a qualifying event has occurred (you have 31 days to enroll from the date of the qualifying event).*

Please select Yes or No to the following questions for yourself (if applicable):	**Please select Yes or No to the following questions for your Spouse (if applicable):**
1) Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No** -If yes, please contact the NMRHCA at 1-800-233-2576 for further instructions 2) Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No** 3) Are you enrolled under private insurance, TRICARE, Federal employee health benefits, VA Benefits, or State Pharmaceutical Assistance Programs? ☐ **Yes** ☐ **No**	1) Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No** -If yes, please contact the NMRHCA at 1-800-233-2576 for further instructions 2) Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No** 3) Are you enrolled under private insurance, TRICARE, Federal employee health benefits, VA Benefits, or State Pharmaceutical Assistance Programs? ☐ **Yes** ☐ **No**

Non-Medicare Plans ***(For applicants not eligible for Medicare benefits)***		**Please Choose One**
	Retiree	
	Spouse	☐ **BCBS Premier PPO** ☐ **Presbyterian Premier PPO**
	Domestic Partner	
	Dependent 1	☐ **Presbyterian Value HMO** ☐ **BCBS Value HMO**
	Dependent 2	

Medicare Plans [1] ***(For applicants eligible for Medicare benefits)***	☐ **BCBSNM Supplemental Plan** ☐ **BCBS Advantage Plan** [1] ☐ **Presbyterian Advantage Plan I**[1] ☐ **Plan II**[1] ☐ **United Healthcare Advantage Plan I** ☐ **Plan II** ☐ **Humana Advantage Plan I** ☐ **Plan II** ______________________________ ☐ Spouse: ______________________ ☐ Dependent: ______________________ ***IMPORTANT:*** *Out-of-state enrollees must select a BCBSNM Supplemental, United Healthcare or Humana Medicare plan.* [1]***Service area for Presbyterian and BCBS Medicare Advantage Plans are limited to the State of New Mexico***	• **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.**

Answering these questions is optional. You can't be denied coverage if you choose to not answer them.

Are you Hispanic, Latino/a or Spanish origin? Select all that apply.

No, not of Hispanic, Latino/a, or Spanish origin ☐ Retiree ☐ Spouse	Yes, Mexican, Mexican American, Chicano/a ☐ Retiree ☐ Spouse
Yes, Puerto Rican ☐ Retiree ☐ Spouse	Yes, Cuban ☐ Retiree ☐ Spouse
Yes, another Hispanic, Latino/a or Spanish origin ☐ Retiree ☐ Spouse	**I choose not to answer** ☐ Retiree ☐ Spouse

What's your race? Select all that apply.

American Indian or Alaskan Native ☐ Retiree ☐ Spouse	Asian Indian ☐ Retiree ☐ Spouse	Black or African American ☐ Retiree ☐ Spouse
Chinese ☐ Retiree ☐ Spouse	Filipino ☐ Retiree ☐ Spouse	Guamanian or Chamorro ☐ Retiree ☐ Spouse
Japanese ☐ Retiree ☐ Spouse	Korean ☐ Retiree ☐ Spouse	Native Hawaiian ☐ Retiree ☐ Spouse
Other Asian ☐ Retiree ☐ Spouse	Samoan ☐ Retiree ☐ Spouse	Other Pacific Islander ☐ Retiree ☐ Spouse
Vietnamese ☐ Retiree ☐ Spouse	White ☐ Retiree ☐ Spouse	**I choose not to answer** ☐ Retiree ☐ Spouse

2. **VOLUNTARY Coverage's** ***(not required; additional premiums charged)***

Dental Plans	☐ **Delta Dental** Comprehensive	☐ **Delta Dental** Basic
Vision Plan	☐ **Davis Vision**	

I Authorization for Deduction / Method of Payment

(ERB retirees are required to select option 2, automatic bank draft)

☐ 1. I hereby authorize a deduction from my pension earnings for NMRHCA insurance plan contributions.
☐ 2. 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.

J

Acceptance of Coverage Statement: I hereby declare that I have read carefully and understand the information on the reverse side of this form and that the information I have provided above is true and complete to the best of my knowledge. I understand that my submission of this application does not constitute acceptance by the NMRHCA; 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; and that **a payment of insurance contributions for my initial two months of coverage is required as a condition of enrollment and is due with this application** (a single contribution will be required in advance for each month thereafter). I understand my premiums may be adjusted from time to time, and I authorize that adjustment in my pension deduction or bank draft. 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 plan and provider to furnish, when applicable, medical information regarding me and my dependents. *(If signing under power of attorney, please attach authorizing documents.)*

Retiree Signature: ______________________**Spouse Signature:** ______________________**Date:**________________

GENERAL ENROLLMENT INSTRUCTIONS

Deadline for Application

General Enrollment Applications are **due in our office within *31 days* after your last day of insurance coverage** through your employer. However, it is best to submit your application **at least one month before but not to exceed 60 days** before your last date of coverage to allow adequate time for the agency to process your application.

Section A

Provide all data requested for retiree or for surviving eligible dependent if retiree is deceased.

Section B

Indicate where you are the Retiree, Surviving Spouse/Dependent of a deceased eligible retiree (fill in the information requested) or Other (please specify).

Section C

ERB = Educational Retirement Board; PERA = Public Employees Retirement Association; Other = independent retirement system of employer who participates with NMRHCA (please specify).

Section D

If you are enrolling yourself alone in the NMRHCA, check “Single”; if you are enrolling yourself and one dependent, check “Two-Party”; if you are enrolling yourself and two or more dependents, check “Family.”

Section E

Call NMRHCA for definition of eligible dependent. Eligible dependents will be enrolled in all plans in which you enroll. If you check “Two-Party” or “Family” in Section D, complete Section E. If your spouse does not qualify as an eligible NMRHCA retiree, check “No” and skip to Section F; if your spouse does qualify, check “Yes,” answer the additional questions. You must attach documentation supporting dependent relationship (marriage certificate, birth certificate, court decree of adoption or legal guardianship, etc.).

Section F

Indicate whether you or any dependents to be enrolled in the NMRHCA have any other insurance (besides Medicare) that will continue after your enrollment.

Section G

Indicate whether you or any dependents to be enrolled in the NMRHCA were disabled at the time of your retirement; if so, provide the information requested in items 1-4 for the disabled party.

Section H

1. **MEDICAL COVERAGE:** *Contact individual insurance carriers with questions regarding plan benefits; review carefully the benefits and limitations of the plan(s) you select. If you and/or your dependents are Medicare-eligible but do not carry Medicare Part A and/or Part B, call the NMRHCA to learn about the consequences.*

   Each enrollee’s level of coverage must be the same; single, two-party or family; spouse/dependent(s) will default to retiree’s selection.

   Out-of-state Non-Medicare members must select a BCBS PLAN. Out-of-state Medicare members can select from either BCBS Supplemental, United Healthcare or Humana Medicare.

   If neither you nor your dependents carry Medicare: Select medical carrier and medical plan for Retiree, Spouse, and Dependent(s) in the “Non-Medicare Plans” section.

   If you do not carry Medicare but your dependents do: Select medical carrier and medical plan in the “Non-Medicare Plans” section for yourself. Select medical plan in the “Medicare Plans” section for your Spouse and/or Dependent(s) (as applicable). Please submit copy of Medicare Card showing Parts A and B.

   If you do carry Medicare but your dependents do not: Select plan in the “Medicare Plans” section and submit Medicare Card showing Parts A and B for yourself. Select medical carrier and medical plan in the “Non-Medicare Plans” section for Spouse and/or Dependent(s).

   If both you and your dependents carry Medicare: Select medical plan in the “Medicare Plans” section. Submit Medicare cards showing Parts A and B for all members.

   If you do not enroll in medical coverage within 31 days of initial eligibility: *You must wait for the next subsequent Open Enrollment period (January 1st to January 31st of every odd numbered year with coverage effective January 1st) to re-enroll unless an involuntary loss of coverage due to a qualifying event has occurred (you have 31 days to enroll from the date of the qualifying event).*

2. **VOLUNTARY COVERAGES:** If you select dental or vision coverage, retiree and dependents will be enrolled in the same plan, with the same levels of coverage. Call individual insurance carriers with questions regarding plan benefits; review carefully the benefits and limitations of the plan(s) you select.

Section I

You **must** select one method of payment for your monthly NMRHCA premiums. ERB retirees are required to select option 2, automatic bank draft.

Section J

Sign and date as indicated. You must enclose payment with this application; please complete the First Premium Payment Worksheet enclosed in your packet to calculate the amount due, and return the Worksheet, payment, and completed Work History Form with this application.

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

If you later have a change in status (e.g., you move, you get divorced), it is your responsibility to notify the NMRHCA in writing of the event.

WORK HISTORY FORM

6300 Jefferson St NE, Suite 150
Albuquerque, NM 87109
1 (800) 233-2576 • (505) 222-6400
(505) 884-8611 fax

Please PRINT CLEARLY.
(Use additional forms if necessary)

Name – Last	First	MI	Social Security No.	Date of Birth

Employer at time of retirement	Date of retirement

Please complete the sections below regarding your employment with ***NMRHCA-participating employers only*** (**shown on the back of this form**). Service as a governing authority member with a participating employer (e.g., county commissioner, city councilor, school board member) or a former NM State Legislator may count toward creditable service. Call 1-800-233-2576 with questions.

Check one pension system for each employer			Dates of Service		Employer (Ex. Agency, department, school, district, etc.)	RHCA Participating Employer		Years/ Months of Service	Internal Use Only
PERA	ERB	Other	From (Date)	To (Date)					
						Y	N		
						Y	N		
						Y	N		
						Y	N		
						Y	N		
						Y	N		
						Y	N		
						Y	N		
						Total Years of Service			

I authorize the NMRHCA to obtain information from the Public Employees Retirement Association of New Mexico (PERA), Educational Retirement Board (ERB), or any other pension system regarding my years of creditable service and all affiliated public employers. I understand that if a future audit of my creditable service with a participating employer shows a discrepancy, any resulting adjustment to my monthly premium will be retroactive to my enrollment date. I also certify that the above information is correct to the best of my knowledge and belief.

Signature ____ **Date** __________________________

New Mexico Retiree Health Care Authority

Participating Entities

STATE OF NEW MEXICO

All State Agencies

EDUCATIONAL INSTITUTIONS

All Public School Districts *and Charter Schools*

Central NM Community College	NM Junior College
Eastern NM University	NM Military Institute
Luna Community College	Northern New Mexico College
Mesalands Community College	Santa Fe Community College
NM Highlands University	Western NM University

COUNTIES

Bernalillo	Lincoln	Sandoval
Chaves	Los Alamos	Santa Fe
Cibola	Luna	Sierra
Colfax	McKinley	Taos
Curry	Rio Arriba	Torrance
Eddy	Roosevelt	Union
Grant	San Juan	Valencia
Lea	San Miguel	

CITIES

Alamogordo	Farmington	Roswell
Albuquerque	Gallup	Santa Fe
Aztec	Jal	Santa Rosa
Belen	Las Cruces	Socorro
Bloomfield	Las Vegas	Sunland Park
Carlsbad	Moriarty	T or C
Clovis	Portales	Texico
Deming	Raton	Tucumcari
Española	Rio Rancho	

TOWNS

Bernalillo	Estancia	Taos
Edgewood	Silver City	Tatum
Elida	Springer	Texico

VILLAGES

Bosque Farms	Jemez Springs	Questa
Chama	Logan	Reserve
Des Moines	Melrose	Tijeras
Fort Sumner	Milan	
Hatch	Pecos	

OTHER

Central Region Education Cooperative	North Central Regional Transit District
Gallup Housing Authority	North Central Solid Waste Authority
High Plains Reg. Educ. Coop #3	NW NM Regional Solid Waste Authority
Lea Regional Education #VII	Raton Housing Authority
Mid-Region Council of Government of New Mexico	Regional Education Coop #6
National Education Association	Region IX Education Cooperative
NE Regional Education Coop #4	Santa Fe Civic Housing Authority
NM Activities Association	S Sandoval Cnty Arroyo Flood Control Auth.
NM State Fair Commission	Southwest NM Council of Governments
NW Regional Education Coop #2	T or C Housing Authority
North Central NM Economic Dev District	Tierra y Montes SWCD

The University of New Mexico and New Mexico State University are **NOT** participating entities with the New Mexico Retiree Health Care. Therefore, years of service there do **NOT** count toward your eligible years of service with the New Mexico Retiree Health Care Authority.

Mark all boxes and complete all sections that apply. Return completed form to NMRHCA 6300 Jefferson St. NE, Suite 150, Albuquerque, NM 87109-3482.

APPLICANT

Your Name (Last, First, Middle)	Group Name **New Mexico Retiree Health Care Authority**	Group Number(s) **645743**

Your Address	City	State	ZIP

Your Soc. Sec. No.	Date of Birth	Phone Number	☐ Male ☐ Female

INSURANCE COVERAGE

Decline Additional (Plan 2) Life Retiree ☐ ____________(Initial) Decline Dependents Life Spouse ☐ ____________(Initial)
Decline Dependents Life Child ☐ ____________(Initial)

To elect coverage, complete the section below associated with the employer group you retired from. For APS or NMPSIA, complete section A. For State of NM (including approved Local Public Bodies), complete section B. For all other eligible employers, complete section C.
Note: Spouse and Child coverage amounts may not exceed the Retiree coverage amount.

Section A: Albuquerque Public Schools (APS) or
New Mexico Public Schools Insurance Authority (NMPSIA) Participating Employer

If you continued Retiree Life with APS or NMPSIA, select from the options below and complete the beneficiary designation section at the end of this form.

Retiree Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
Spouse Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
Child(ren) Options:	☐ $2,500	☐ $5,000	☐ $10,000		

If you did not continue Retiree life with APS or NMPSIA, but can provide proof of the life insurance amounts you lost with these groups, select from the options below (up to insurance amounts lost) and complete the beneficiary designation section at the end of this form. *An Evidence of Insurability Statement is required for coverage amounts over $10,000 for Retiree and Spouse, if proof of the insurance amounts lost is not available, and for elected coverage amounts above insurance amounts lost.*

Retiree Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
	☐ $15,000	☐ $20,000	☐ $40,000	☐ $46,000	☐ $60,000
Spouse Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
	☐ $15,000	☐ $20,000	☐ $40,000	☐ $46,000	☐ $60,000
Child(ren) Options:	☐ $2,500	☐ $5,000	☐ $10,000		

Section B: State of NM (Including approved Local Public Bodies)

Select from the options below and complete the beneficiary designation section at the end of this form. *An Evidence of Insurability Statement is required for Retiree coverage at the $60,000 level and for Spouse coverage amounts over $10,000.*

Retiree Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
	☐ $15,000	☐ $20,000	☐ $40,000	☐ $46,000	☐ $60,000
Spouse Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
	☐ $15,000	☐ $20,000	$40,000	☐ $46,000	☐ $60,000
Child(ren) Options:	☐ $2,500	☐ $5,000	☐ $10,000		

Section C: Other NMRHCA Participating Employer's Name: ________________________________

Select from the options below and complete the beneficiary designation section at the end of this form. *An Evidence of Insurability Statement is required for coverage amount over $10,000 for Retiree and Spouse.*

Retiree Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
	☐ $15,000	☐ $20,000	☐ $40,000	☐ $46,000	☐ $60,000
Spouse Options:	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000
	☐ $15,000	☐ $20,000	☐ $40,000	☐ $46,000	☐ $60,000
Child(ren) Options:	☐ $2,500	☐ $5,000	☐ $10,000		

Member Name	Social Security Number

BENEFICIARY

This designation applies to Life Insurance available through NMRHCA. Designations are not valid unless signed, dated, and delivered to NMRHCA during your lifetime. See below for further information.

Primary - Full Name	Address	Phone No.	Soc. Sec. No.	Relationship	Basic Life %	Additional Life %

Contingent - Full Name	Address	Phone No.	Soc. Sec. No.	Relationship	Basic Life %	Additional Life %

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or cost changes.

If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.

Retiree Signature Required	Date (Mo/Day/Yr)

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated ____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

FIRST PREMIUM PAYMENT WORKSHEET

Please use this worksheet to calculate the amount of your payment for the first two months' premium to be enclosed with your General Enrollment Application. Be sure to enter the appropriate amounts from the "Single," "Two-Party," or "Family" column shown on the current rate sheet. The level of coverage (single, two-party, or family) must be consistent for all coverage you select, and an eligible retiree must enroll to allow dependent enrollment.

If you do not enclose payment with your application forms, we will be unable to process your application.

1. Enter the total amount of your Medical Plan Monthly Premium Contribution from the current rate sheet (including dependent premiums, if applicable). This amount includes medical insurance and a prescription drug program. • If you are enrolling children, enter rate from **Child Rate** row multiplied by number of children. • Ex: # of Children: ______x Child Rate: _________= Total for Child(ren): _________	+ $__________ *Retiree* + $__________ *Spouse/Partner (if applicable)* + $__________ *Child(ren) (if applicable)*
2. ***If you selected a dental plan,*** enter the amount of your Dental Plan Monthly Premium from the rate sheet.	+ $__________
3. ***If you selected the vision plan,*** enter the amount of your Vision Plan Monthly Premium from the rate sheet.	+ $__________
4. ***If you selected life insurance,*** enter the amount(s) of Retiree and/or Dependent Supplemental Life from the rate sheet.	+ $__________ *Retiree* + $__________ *Spouse/Partner (if applicable)* + $__________ *Dependent(s) (if applicable)*
SUBTOTAL	$__________
Times First 2 Months	**x 2**
TOTAL: ***Enclose payment of this amount (check, cashier's check or money order made payable to the NMRHCA) with your application, work history form, and this worksheet.***	= **$**__________

If you have any questions, please call the New Mexico Retiree Health Care Authority at 1-800-233-2576 or 505-476-7340 (in Santa Fe).

NEW MEXICO
RETIREE
HEALTH CARE

BOARD OF DIRECTORS:
THERESE SAUNDERS
PRESIDENT
TOMAS SALAZAR
VICE PRESIDENT
LEANNE LARRAÑAGA-RUFFY
SECRETARY
NEIL KUEFFER
EXECUTIVE DIRECTOR

Notice of Privacy Practices

Purpose of this Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The New Mexico Retiree Health Care Authority (NMRHCA) group health plan, including the self-funded (Medicare and non-Medicare) medical and prescription drug plan options, COBRA administration, and administration of an External Review process incorporating Independent Review Organizations, (hereafter referred to as the "Plan") is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to Protected Health Information including:

1. The Plan's uses and disclosures of PHI,
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS),
5. The person or office you should contact for further information about the Plan's privacy practices, and
6. To notify affected individuals following a breach of unsecured Protected Health Information.

PHI use and disclosure by the Plan is regulated by the Federal law, Health Insurance Portability and Accountability Act, commonly called HIPAA. You may find these rules in Section 45 of the Code of Federal Regulations, Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

Effective Date

The effective date of this Notice is July 1, 2019, and this notice replaces notices previously distributed to you.

Privacy Officer

The Plan has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

Privacy Officer for the NMRHCA
Director of Communications
6300 Jefferson St. NE, Suite 150, Albuquerque, NM 87109
Telephone: 505-222-6403 Email: RHCA.Security@rhca.nm.gov

Your Protected Health Information

The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI does not include health information contained in records held by NMRHCA related to health information on disability, work- life insurance, dependent care flexible spending accounts, etc.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your written authorization in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- ***For treatment, payment or health care operations.*** The Plan and its Business Associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization or opportunity to agree or object in order to carry out treatment, payment, or health care operations.

Definitions and Examples of Treatment, Payment, and Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. • ***For example:*** The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care. • ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as "Business Associates."
Health Care Operations keep the Plan operating soundly.	Health care operations includes but is not limited to quality assessment and improvement, patient safety activities, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs and general administrative activities. • ***For example:*** The Plan uses information about your medical claims to refer you to a health care management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

The Plan does not need your consent or authorization to release your PHI when you request it, a government agency requires it, or the Plan uses it for treatment, payment, or health care operations.

The Plan Sponsor has amended its Plan documents to protect your PHI as required by Federal law. The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment, and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

When the Disclosure of Your PHI Requires Your Written Authorization

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI other than:

- When you request your own PHI
- A government agency requires it, or
- The Plan uses it for treatment, payment or health care operation.

You have the right to revoke an authorization.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (meaning a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of Protected Health Information if the Plan receives direct or indirect financial remuneration (payment) from the entity to which the PHI is sold. The Plan does not intend to engage in fundraising activities.

Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

1. When **Required by Law.** As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.
2. When permitted **for purposes of public health activities.** This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. To a school about an individual who is a student or prospective student of the school if the Protected Health Information that is disclosed is limited to **proof of immunization**, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis (in place of the parent) of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.
4. When authorized by law to report information about **abuse, neglect or domestic violence** to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
5. To a **public health oversight agency for health oversight activities authorized by law.** We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.
6. When required for **Judicial and Administrative Proceedings.** For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
   - the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written notice, and
   - the notice provided sufficient information about the proceeding to permit you to raise an objection, and
   - no objections were raised or were resolved in favor of disclosure by the court or tribunal.
7. When required for **Law Enforcement purposes.** We may disclose your health information if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law

enforcement purposes include identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

8. When required for **Law Enforcement Health Purposes**. For example, to report certain types of wounds.
9. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.
10. **Organ and Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
11. **Public Safety.** We may disclose your health information to appropriate persons if the Plan in good faith believes the use or disclosure is necessary in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. When required for **Specialized Government Functions**. We may disclose your health information for military authorities under certain circumstances, to authorized federal officials for lawful intelligence, counter-intelligence and other national security activities.
13. **Workers' Compensation.** We may disclose your health information to comply with workers' compensation or similar programs established by law.
14. For **Research**, subject to certain conditions.

When NMRHCA May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Under this Plan your PHI will automatically be disclosed to appropriate internal departments at NMRHCA as outlined below. **If you disagree with this automatic disclosure by the Plan you may contact the Privacy Officer to request that such disclosure not occur without your written authorization.** In the event of your death while you are covered by this Plan, when the Plan is notified it will automatically communicate this information to NMRHCA's Customer Service Department.

Your Personal Representative

You may exercise your rights to your Protected Health Information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf before the Personal Representative will be given access to your PHI or be allowed to take any action for you.

Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

This Plan WILL AUTOMATICALLY recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan **not** automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (copy attached to this notice or also available from the Privacy Officer).

If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form (attached or available from the Privacy Officer) and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.

The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of PHI related to treatment, payment and health care operations purposes under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have dependent children age 18 and older covered under the Plan, and the child wants you, as the parent(s), to be able to access their Protected Health Information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the retiree) and/or your Spouse as their Personal Representatives.

The Plan will consider a parent, guardian, or other person acting in loco parentis as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. In loco parentis may be further defined by State law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

You may obtain a form to Appoint a Personal Representative or Revoke a Personal Representative by contacting the Privacy Officer at their address listed on this Notice.

Statement of Your Individual Privacy Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. NMRHCA is not required to agree to the restrictions that you request if the Plan Administrator or Privacy Officer determines it to be unreasonable. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Officer at their address listed on the first page of this Notice.
2. **Right to Request Confidential Communications.** You have the right to receive your health information through a reasonable alternative means or at an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you must submit your request in writing to the main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107.
3. **Right to Inspect and Copy.** You have the right to inspect and copy (in hard copy or electronic form) health information about you (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as NMRHCA maintains the PHI. To inspect and copy such information, you must submit your request in writing to the Privacy Officer at their address listed on the first page of this Notice. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.
4. **Right to Request Amendment.** You have a right to request that NMRHCA amend your health information that you believe is incorrect and incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about your denial and how you can disagree with the denial. To request an amendment, you must make your request in writing to the Privacy Officer at their address listed on the first page of this Notice. You must provide a reason for your request.

5. **Right to Accounting of Disclosures.** You have the right to receive a list or "accounting of disclosures" of your health information made by NMRHCA, except that we do not have to account for disclosures made for purposes of treatment, payment functions or health care operations, or disclosures made to you or authorized by you in writing. To request this accounting of disclosures, you must submit your request in writing to the Privacy Officer at their address listed on the first page of this Notice. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. NMRHCA will provide one list per 12-month period free of charge; we may charge you a reasonable cost-based fee for additional lists.
6. **Right to Paper Copy of this Notice.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time. This right applies even if you have agreed to receive the Notice electronically. To obtain a paper copy of this Notice, send your written request to the Privacy Officer at their address listed on the first page of this Notice.
7. **Breach Notification.** If a breach of your unsecured Protected Health Information occurs, the Plan will notify you.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights contact the Privacy Officer at their address or telephone number listed on the first page of this Notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services in accordance with their enforcement activities under HIPAA,
- Uses of disclosures required by law, and
- Uses of disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. **De-identified information** is information that does not identify you and there is no reasonable basis to believe that the information can be used to identify you.

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. **Summary health information** means information that summarizes claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Change to this Notice of Privacy Practices

NMRHCA reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, NMRHCA is required by law to comply with the current version of this Notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on the first page of this Notice. NMRHCA will not retaliate against you in any way for filing a complaint. All complaints to NMRHCA must be submitted in writing.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website:

https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html or contact the Privacy Officer (noted on the first page of this Notice) for more information about how to file a complaint.

If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer at the address listed on the first page of this Notice.