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.

Please contact NMRHCA (1-800-233-2576) if an application is needed.

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

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

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

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	Marital Status
			☐ Male ☐ Female	☐ 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.)*

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	☐ **BCBS Premier PPO** ☐ **Presbyterian Premier PPO** ☐ **Presbyterian Value HMO** ☐ **BCBS Value HMO**
	Spouse	
	Domestic Partner	
	Dependent 1	
	Dependent 2	

Medicare Plans [1] *(For applicants eligible for Medicare benefits)*

☐ **BCBSNM Supplemental Plan**
☐ **BCBS Advantage Plan I**[1] ☐ **Plan II**[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.**

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.

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

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

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		
						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.

Standard Insurance Company

Initial Life Insurance Enrollment Form

Mark all boxes and complete all sections that apply. Return completed form to NMRHCA 4308 Carlisle NE, Suite 104, Albuquerque, NM 87107.

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 <u>not</u> 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, <u>if</u> proof of the insurance amounts lost is not available, and for elected coverage amounts <u>above</u> 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	% of Benefit

Contingent - Full Name	Address	Phone No.	Soc. Sec. No.	Relationship	% of Benefit

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
AUTHORITY

Notice of Privacy Practices

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

The New Mexico Retiree Health Care Authority (NMRHCA) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at NMRHCA, please contact our main office located at 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107, or by telephone at 1-800-233-2576.

How NMRHCA May Use or Disclose Your Health Information

The following categories describe the ways that NMRHCA may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.
2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.
3. **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.
4. **Public Health.** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease; injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; or reporting disease or infection exposure.
5. **Health Oversight Activities.** 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. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding.
7. **Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
8. **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.
9. **Organ and Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
10. **Public Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
11. **National Security.** We may disclose your health information for military, national security, prisoner and government benefits purposes.
12. **Workers' Compensation.** We may disclose your health information to comply with workers' compensation or similar laws.
13. **Marketing.** We may contact you to provide information about health-related benefits and services that may be of interest to you.
14. **Disclosures to Plan Spouses**. We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

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.

Statement of Your Health Information 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 you would like to make a request for restrictions, you must submit your request in writing to our main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107.
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. To request confidential communications, you must submit your request in writing to the main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107. We are not required to agree to your request.
3. **Right to Inspect and Copy.** You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to the main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107. 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 main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107. 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 us, except that we do not have to account for disclosures made for purposes of payment functions or health care operations, or made by you. To request this accounting of disclosures, you must submit your request in writing to the main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107. 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 for additional lists.
6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107.

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 main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107, or by telephone at 1-800-233-2576.

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

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to the main office, 4308 Carlisle Blvd NE, Suite 104, Albuquerque, NM 87107. NMRHCA will not retaliate against you in any way for filing a complaint. All complaints to NMRHCA must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

Effective Date of This Notice: April 14, 2003