CHANGE REQUEST FORM

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

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

Please see instruction sheet attached and PRINT CLEARLY.

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

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

B Change Personal Information

1. ☐ CHANGE ***ADDRESS***: *Write* **new** *address & phone no. in Section 5*
2. ☐ CHANGE ***NAME***: a. *Write* **new** *name in Section A-2* b. *Write* **former** *name here:*

C Change Level of Coverage *(Each enrollee's level of coverage must be the same; unless one party is Medicare eligible).*

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

2. ***ADD*** *DEPENDENT(S)/DOMESTIC PARTNER:* ***List in #4 below***
   a. ☐ Marriage date: ____/____/____ ***(attach certificate)*** c. ☐ Newly eligible ***(attach supporting documents)***
   b. ☐ Newborn birth date: ____/____/____***(attach certificate)***

3. ***DEPENDENTS***

a. Soc. Sec. #	b. Full name	c. Date of birth (MM/DD/YYYY)	d. Sex	e. Relationship	f. Medicare Part A	f. Medicare Part B
			☐M ☐F		☐Y ☐N	☐Y ☐N
			☐M ☐F		☐Y ☐N	☐Y ☐N
			☐M ☐F		☐Y ☐N	☐Y ☐N

4. **Medical Coverage:**

Please select Yes or No to the following questions for yourself:
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**

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**

Non-Medicare Plans

Name_____

Name_____

Choose one plan for all non-Medicare members
(Out-of-state non-Medicare enrollees must select BCBS Premier)
- ☐ **BCBS Premier PPO**
- ☐ **Presbyterian Premier PPO**
- ☐ **Presbyterian Value HMO**
- ☐ **BCBS Value HMO**

Medicare Plans [1]

([1]Service area for Presbyterian and BCBS Advantage Plans are limited to the State of New Mexico)

- ☐ **BCBSNM Medicare Supplemental Plan**
- ☐ **BCBS Advantage Plan I** ☐ **Plan II**
- ☐ **Presbyterian Advantage Plan I** ☐ **Plan II**
- ☐ **United Healthcare Advantage Plan I** ☐ **Plan II**
- ☐ **Humana Advantage Plan I** ☐ **Plan II**

☐ Spouse: _____

☐ Dependent: _____

- **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

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

☐ Delta Dental Comprehensive	☐ Delta Dental Basic	☐ Davis Vision

D Cancel Coverage

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

Retiree	**Spouse/Domestic Partner**	**Dependent**
☐ Cancel my medical plan ☐ Cancel my dental plan[1] ☐ Cancel my vision plan[1] ☐ Cancel my Supplemental Life plan ☐ Cancel ***all*** benefit plans for all members[1]	☐ Cancel medical plan ☐ Cancel dental plan[1] ☐ Cancel vision plan[1] ☐ Cancel Supplemental Life plan	☐ Cancel medical plan ☐ Cancel dental plan[1] ☐ Cancel vision plan[1] ☐ Cancel Supplemental Life plan
	Name: _____	**Name:** _____ **Name:** _____

[1]*If you drop dental or vision coverage you must wait four years before enrolling again.*

E Change Amount of Life Insurance

Decrease Coverage

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

Increase* Coverage

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

Losing Retiree Life coverage from New Mexico Public Schools Insurance Authority (NMPSIA) due to age:
With proof of life insurance amounts lost from NMPSIA and enrolling within 31 days of the loss you may enroll up to the insurance amounts lost.

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

Add* Coverage

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

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

F Change Method of Premium Payment / Retiree Authorization for Deduction

(ERB retirees are required to select option 2, automatic bank draft, if changing the method of payment)

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.

G DECLARATION AND SIGNATURE

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

Signature _____ **Date** _____

Spouse Signature _____ **Date** _____

CHANGE REQUEST FORM INSTRUCTIONS

Section A

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

Section B

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

Section C

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

Section D

*Complete only if you wish to **cancel** coverage.* Future reapplication for NMRHCA medical plan coverage may require submission of a Loss of Coverage letter for retiree and any dependents to be covered. If you cancel only dental or vision coverage, you must wait four years before enrolling again during the subsequent Switch Enrollment Period. If you cancel only retiree and/or dependent additional life, future reapplication will require submission of an Evidence of Insurability Statement for each individual to be covered by additional life insurance.

Section E

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

Section F

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

Section G

You MUST sign and date this form. Send original to NMRHCA, 6300 Jefferson St NE, Suite 150, Albuquerque NM 87109; keep a copy for your records.

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