

SWITCH ENROLLMENT FORM



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

Please PRINT CLEARLY

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

Social Security No.	PRINT Last Name		First Name	MI
Date of Birth (MM/DD/YYYY)	Mailing Address — If new, check box: ☐			
Effective Date of Change January 1, 2027	City	State	ZIP Code	Home Phone ()
Email address:				Mobile Phone ()

B SWITCH Medical Plan /Selection of New Plan (Each enrollee's level of coverage must be the same; unless one party is Medicare eligible; spouse/dependents will default to retiree's selection).

Non-Medicare Plans (For applicants not eligible for Medicare benefits)	Retiree	<u>Select only one</u> ☐ BCBS Premier PPO ☐ Presbyterian Premier PPO ☐ BCBS Value HMO ☐ Presbyterian Value HMO
	Spouse	
	Domestic Partner	
	Dependent 1	
	Dependent 2	
Medicare Plans (For applicants eligible for Medicare benefits)	☐ BCBS Medicare Supplemental Plan ☐ BCBS Medicare Advantage HMO ¹ ☐ BCBS Medicare Advantage PPO ☐ United Healthcare Medicare Advantage PPO + PDP ☐ Humana Medicare Advantage PPO + PDP ☐ Spouse: _____ ☐ Dependent: _____ Out-of-state enrollees must select from BCBSNM Supplemental or United Healthcare Advantage or Humana Medicare Advantage ¹ Service area for Presbyterian Adv. and BCBS Adv. are limited to the State of New Mexico	Medicare Part A and Part B are required for all Medicare Plans

C SWITCH Dental Plan or ADD Dental or Vision Plan / Selection of New Plan

1. DENTAL ☐ Delta Dental Comprehensive ☐ Delta Dental Basic ☐ BCBS Dental Comprehensive ☐ BCBS Dental Basic	2. VISION ☐ Davis Vision
--	---

D Cancel Coverage

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 <u>all</u> benefit plans for all members	☐ 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

¹If you drop dental or vision coverage for any reason, you must wait four years before enrolling again.

E DECLARATION AND SIGNATURE

I hereby declare the information I have provided above is true and complete to the best of my knowledge.
(If signing under power of attorney, please attach authorizing documents.)

Signature _____ Date _____

Spouse Signature _____ Date _____