**B****enefit Services** Hadley Hall, Room 17 MSC 3HRS, PO Box 30001

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benefits@nmsu.edu

Enrollment Application / Change Form – Dental and Vision

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| --- | --- | --- | --- | --- |
| **New Mexico State University Account #265001**Group # Dental 268431**Account #26500**Group # Vision: GFZ02001 | 0001000200039902 | Non MedicareNon Medicare Surviving Deps Medicare <70COBRA Admin | 000400050101 | Medicare Surviving Deps Medicare 70+Dental-No Medical Coverage |
| **Section 1 – Enrollment Event** |
| [ ]  Open EnrollmentDue by: November 15, 2023Effective Date of Benefits: **01/01/2024**[ ]  New Enrollee [ ]  Add Dependent | Cancel coverage: Dental VisionCancel Enrollee (& Dependents) Cancel Dependent**Please note: If you terminate coverage you may not re-enroll until after a 4-year waiting period and only during open enrollment.** |
| **Section 2 – Please tell us about yourself** |
| Name (Last) |  | (First) |  |  | (MI) |  | Date of Birth | Aggie ID # |
| Mailing Address (Street) |  | (City) |  | (State) | (Zip Code) | Phone | Social Security # | Sex[ ] Female [ ]  Male |
| **Dental Coverage**Yes No | **Who is covered? (select one)**Retiree onlyRetiree + Spouse/DP Retiree + Child (ren) Retiree + Family | **Vision Coverage**Yes No | **Who is covered? (select one)**Retiree only Retiree + One Retiree + Family |
| **Dependents:** |
| **Husband Wife****Domestic Partner** | **Dependent Name:** | **Male** | **Female** |
|  | **Dependent SSN:** | **Birthdate: (mm/dd/yyyy)** |
| **Son Daughter****Other Dependent** | **Dependent Name:** | **Male** | **Female** |
|  | **Dependent SSN:** | **Birthdate: (mm/dd/yyyy)** |
| **Son Daughter****Other Dependent** | **Dependent Name:** | **Male** | **Female** |
|  | **Dependent SSN:** | **Birthdate: (mm/dd/yyyy)** |
| **Son Daughter****Other Dependent** | **Dependent Name:** | **Male** | **Female** |
|  | **Dependent SSN:** | **Birthdate: (mm/dd/yyyy)** |
| * **I am an employee of the employer or a retiree named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer’s plan, which is underwritten or administered by Blue Cross and Blue Shield of New Mexico. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct.**
* **I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).**
* **Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).**
* **I agree that my employer acts as my agent. I authorize necessary payroll deductions by my employer, if any, to cover the cost of my coverage(s).**
* **I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.**
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| 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. |
| Applicant’s Signature | Date: |