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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 | | | 0001  0002  0003  9902 | Non Medicare  Non Medicare Surviving Deps Medicare <70  COBRA Admin | | | | | 0004  0005  0101 | | Medicare Surviving Deps Medicare 70+  Dental-No Medical Coverage | | | |
| **Section 1 – Enrollment Event** | | | | | | | | | | | | | | |
| Open Enrollment  Due by: November 15, 2023  Effective Date of Benefits: **01/01/2024**  New Enrollee  Add Dependent | | | | Cancel coverage: Dental Vision  Cancel 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 only  Retiree + 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.** | | | | | | | | | | | | | | |
| 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: | | | | | | |