MOUNTAINAIR PUBLIC SCHOOLS

DEPARTING EMPLOYEE INFORMATION

1.) Notify Mountainair Public School Superintendent of your planned departure. Mountainair Public Schools requires 30-day notice for resignation. Notification MUST be in writing or email format.
2.) Notify your site administrator.
3.) Get in contact with Business Manager to discuss deductions and other HR related items. Do not delay. This may have an effect on your final paycheck. Business Manager will schedule meeting with you prior to your departure. There is paperwork that needs to be completed before you leave the district.
4.) Print the next page and bring with you to your site administrator in the final days before your departure. Please complete all tasks on the Departing Employee Form.

MOUNTAINAIR PUBLIC SCHOOLS
DEPARTING EMPLOYEE FORM

EMPLOYEE NAME: ____

TODAY'S DATE: _______________   FINAL DAY: ______________________

SITE RELATED

☐ CHECK-IN KEYS

☐ PAY ALL OUTSTANDING EXPENSES

LUNCH FEES / DAMAGED PROPERTY / ETC.

☐ CHECK-IN BADGE / CODE

TECHNOLOGY RELATED

☐ LOGIN TO COMPUTER / IPAD TO CHANGE PASSWORD TO GENERAL PASSWORD FOR ADMINISTRATOR

☐ TURNED IN ALL TECHNOLOGY INCLUDING CHARGERS

HR RELATED

☐ UNDERSTAND THAT FINAL CHECK MAY BE A PAPER CHECK AND MAILED

☐ ADVISED TO SPEAK TO BUSINESS MANAGER ABOUT DEDUCTIONS, PLEASE DO SO IMMEDIATELY TO PREVENT DELAY IN FINAL CHECK.

☐ MAKE SURE MAILING ADDRESS, EMAIL ADDRESS AND PHONE NUMBER ARE UPDATED AT CENTRAL OFFICE.

OTHER

☐ ____

☐ ____

☐ ____

EMPLOYEE SIGNATURE: ____

SITE ADMIN SIGNATURE: _______________________________________

For Employer Use: PAYROLL DEDUCTIONS	MEDICAL	DENTAL	VISION	DISABILITY	ADDITIONAL LIFE	Former Employer (if covered under NMPSIA)	Basic Life Eff. Date (mm/dd/yyyy)	Other Cvg Eff. Date (mm/dd/yyyy)
	$	$	$	$	$			

New Mexico Public Schools Insurance Authority

EMPLOYEE CHANGE CARD

Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943

District/Entity Name	District/Entity #

1

Social Security Number	Name (Last, First, Middle)	Date of Birth

Mailing Address	City	State	Zip Code	Home Phone Number

Marital Status	Gender	Preferred E-Mail Address	Work Phone Number	Cell Phone Number
☐ S ☐ M	☐ F ☐ M	By furnishing my e-mail address on this form, I am consenting to receive communications related to my participation in NMPSIA's benefit program by e-mail. ☐ Check this box only if you do NOT wish to receive plan communications by e-mail.		

REASON FOR CHANGE:

☐ Late Enrollment ☐ New address and/or phone number

☐ Open/Switch Enrollment ☐ Qualifying Event

Answer questions below

What event took place? ______

What date did event take place? ______

2 ENROLLMENT

What is your current enrollment status?	☐ Employee Only	☐ 2-Party (Employee + Spouse or Child)	☐ Family (Employee + 2 or more)
What enrollment status are you requesting?	☐ Employee Only	☐ 2-Party (Employee + Spouse or Child)	☐ Family (Employee + 2 or more)

Check One: ☐ **ADD COVERAGE** ☐ **CANCEL COVERAGE** ☐ **SWITCH ENROLLMENT**

☒ BASIC LIFE: The Standard

MEDICAL:

☐ **Blue Cross Blue Shield of NM**
- ☐ High Option (*Default*)
- ☐ Low Option
- ☐ EPO Option

☐ **Cigna**
- ☐ High Option Plan (*Default*)
- ☐ Low Option Plan

☐ **Presbyterian**
- ☐ High Option (*Default*)
- ☐ Low Option

☐ Decline Medical

Reason: ______

Eligible for Medicaid? ☐ Yes ☐ No

DENTAL: **Delta Dental:** ☐ High Option (*Default*) ☐ Low Option **United Concordia:** ☐ High Option (*Default*) ☐ Low Option ☐ Decline Dental

☐ **VISION**: **Davis Vision** (2 year enrollment required) ☐ Decline Vision

☐ **LONG TERM DISABILITY**: **The Standard** (Qualifying Event or Evidence of Insurability) ☐ Decline Long Term Disability

☐ **ADDITIONAL LIFE**: **The Standard** (Qualifying Event or Evidence of Insurability) **Select:** ☐ 1X ☐ 2X ☐ 3X Base Annual Salary ☐ Spouse Life ☐ Child Life ☐ Decline Employee Additional Life ☐ Decline Dependent Life

3 DEPENDENT INFORMATION

List all dependents you wish to enroll. Provide requested information for additional dependents on separate sheet if necessary.
Indicate an A (add), D (drop), C (continue coverage), or N/A (not applicable) for all names listed below.

Med	Dntl	Visn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number **(REQUIRED)**	Date of Birth (mm/dd/yyyy)	Gender	Dependent's Relationship to You	Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No

4 EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that services will be available subject to the exclusions, limitations and the conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined this application and supporting documentation, and to the best of my knowledge and belief, they are true, correct, and complete. **Read reverse side before signing**.

EMPLOYEE SIGNATURE ______________________ DATE ______________

RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR QUALIFYING EVENT

5 EMPLOYER CERTIFICATION

ONLY complete this section for QUALIFYING EVENTS: Part-time to Full-time with a salary increase; Promotion into a new job class with a salary increase; Decrease in salary and hours worked per week. FORM MUST BE SIGNED BY EMPLOYER.

I attest that to the best of my knowledge that this applicant is an employee of my district/entity (or meets the one-bus owner definition) and works the minimum number of hours per week required for NMPSIA benefits.

Date of Hire	Base Annual Salary	# of hours worked weekly	Job Title	☐ Check *only* if Variable Hour Employee	List date Variable Hour Employee became eligible for **medical only** coverage	Date Received in Your Office
	$					

BENEFITS SPECIALIST SIGNATURE: **DATE:**

Revised September 2020

Please read the NMPSIA Program Guide (provided to you by your employee benefits office) as you complete this change card.

NMPSIA's Program Guide outlines the NMPSIA Eligibility Rules and administrative guidelines for enrollment. If you do not have this Guide, you can obtain a copy from your school district/entity benefits office or at https://nmpsia.com.

ELIGIBILITY

If you are reporting a change in status, you must turn in this form within 31 days from your qualifying event.

Contractors are not eligible to participate in NMPSIA coverage*, except for one-bus owners. Fleet bus owners and their employees* ***are not*** *eligible to participate in NMPSIA coverage.*

To be eligible for NMPSIA Group Coverage, you must work the minimum number of hours per week established by your employer. In most cases, employees are eligible for basic life insurance coverage when they work a minimum of 15 hours per week. In most cases employees are eligible for all other lines of coverage when they work a minimum of 20 hours per week. Variable hour employees should confirm eligibility for benefits with their Employee Benefits Office.

Basic life insurance coverage is effective the first day of the month following your date of hire -- first day actively at work on contract. If you meet this requirement, your employer will enroll you in basic life even if you decline (or are not eligible to participate) in any other line of NMPSIA coverage. Subject to the actively at work provision, the effective date for all your other lines of coverage is determined by your employer. This effective date can never be any sooner than your basic life effective date and can never be made retroactive (prior to the date you officially apply).

SALARY INFORMATION

NMPSIA uses your base annual salary to determine your additional life (ADL) coverage and long term disability (LTD) coverage. For ADL and LTD insurance purposes, your employer will not prorate your salary if you begin after the school year AND your employer will not include salary increments for other duties, such as coaching, department head, yearbook, etc.

ENROLLMENT

You may only apply for the lines of NMPSIA coverage offered by your employer.

Please keep the following in mind:

- If you decline medical coverage within 31 days of becoming eligible, you may apply to enroll in NMPSIA medical coverage within 31 days from a qualifying event or special enrollment event, or enroll during open enrollment for medical coverage in the fall with an effective date of January 1st.
- You may enroll as employee only for any line of NMPSIA coverage.
- If you enroll in vision coverage, you and each of your enrolled dependents must meet the 24-month enrollment requirement before you can cancel this coverage.
- If you enroll for ADL coverage, you may apply for coverage up to 1x, 2x, or 3x your base annual salary. You may also apply for life coverage for your spouse at the rate of 1x your salary or 50% of your additional life coverage, *whichever is less*. You may also insure your dependent children for $5,000 of life coverage.
- If you decline ADL or LTD coverage, you may apply through the evidence of insurability process. The carrier will make a determination on this application.
- If you decline dental and/or vision coverage, you may not enroll late to either of these plans unless you apply within 31 days from involuntarily losing other dental and/or vision coverage, or enroll during the open enrollment for dental/vision in the fall with an effective date of January 1st.

Indicate the status *(employee only, two-party, or family)* for each line of coverage. If you enroll one eligible dependent, you must enroll all eligible dependents, unless one or more dependents have other coverage. When enrolling dependents, you may exclude a dependent from a particular line of NMPSIA coverage only if you provide evidence that the dependent you are excluding has that particular line of coverage elsewhere. In this case, evidence of the other coverage is required *(i.e., letter of insurance verification, insurance ID card with dependent's name listed, etc.)*. If you are excluding a dependent and do not provide this evidence, the dependents you are enrolling will suffer a delay in coverage until such evidence is provided. There is a 61-day deadline from your effective date of coverage to provide such evidence.

If both you and your spouse work for the same employer or for another NMPSIA affiliated employer, you and your spouse cannot double insure each other and your dependents under the NMPSIA Group Plan for any line of NMPSIA coverage. *(i.e., You work for Las Cruces Public Schools and carry family medical, dental, vision, additional life insurance coverage for yourself, your spouse, and your children. Your spouse who is employed with Deming Public Schools cannot apply for family coverage to insure him, you and your children for these lines of NMPSIA coverage since you already carry this NMPSIA coverage at Las Cruces Public Schools. You and your spouse may decide it is best to carry the additional life independent from each other, and then the children can be insured either under your plan or your spouse's plan.)*

To enroll your spouse and/or your married or unmarried children (who are up to 26 years old) for any line of NMPSIA coverage offered by your employer, you will be required to present your employee benefits office with copies of the supportive documentation to prove eligibility for your dependents.

To enroll your spouse, present your **official state publicly filed marriage certificate** (from the County Clerk's Office). You may provide a chapel marriage certificate, but NMPSIA reserves the right to request the official state copy at any time. If you divorce, you must report this within 31 days and cancel coverage for your ex-spouse effective the last day of the month the divorce is final. You will be required to provide copies of certain pages of your final divorce decree. Covering an ex-spouse is considered misrepresentation.

To enroll your married or unmarried children *(who are up to 26 years old)* for any line of NMPSIA coverage offered by your employer, present their **official state publicly filed birth certificates** *(from the Bureau of Vital Statistics)*. You may provide hospital birth certificates, but NMPSIA reserves the right to request the official state copy at any time.

Coverage for your dependents will begin on your effective date of coverage when you provide your employee benefits office with the appropriate supportive documentation at the time of application or prior to your coverage going into effect. You have 61 days from your effective date of coverage or 61 days from your qualifying event to provide the appropriate supportive documentation for your dependents, but their effective date of coverage will be on the first day of the month following the date your employee benefits office receives this documentation. Coverage for your dependents will not be made retroactive. If you do not provide this information within 61 days, you may apply to cover your dependents during the established open enrollment period in the fall for coverage that will become effective on January 1.

Medical and Prescription Drug Coverage – If you enroll in the medical plan, you are automatically enrolled in the Prescription Drug Program. You will receive a separate ID card from the NMPSIA Prescription Drug Manager to purchase your prescription drugs.

BENEFICIARY INFORMATION

Complete a **Schedule A** form to make your selection(s) for your beneficiary for basic life and/or additional life coverage. You may change your beneficiary designation at any time. If you do not designate a beneficiary for your life insurance, the life insurance carrier will apply its established processes to determine the individual(s) entitled to your life benefit.

CONFIRMATION OF ENROLLMENT

Once your enrollment has been processed, the NMPSIA Eligibility Administrative Office will email you or mail you a Confirmation of Enrollment Notice to your *home (and to your employer)*. Please review this confirmation notice carefully and report any discrepancies to your Employee Benefits Office or to the NMPSIA Eligibility Administrative Office at 1 (800) 233-3164.

If you do not provide your employer with all of the appropriate documentation necessary to finalize your enrollment request, you will be contacted for the appropriate documentation. Please be sure to adhere to all deadlines associated with this request.

Return completed form to: P O Box 26129 Santa Fe, NM 87502-0129 (866) 691-2345

Request For Refund and/or Rollover

See page 2 for instructions. Mail completed original application to the address above.
Fill out form using black and blue ink only. Forms with white-out will be rejected. DO NOT FAX APPLICATION.

Section I: Member Information

Name: ______________________ **SSN**: ______________ **DOB**: ______________ ☐ **Male** ☐ **Female**

Address: ______________________________ City State Zip **Phone**: ______________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Married, previously divorced** * ☐ **Divorced** * ☐ **Widowed**

***** *Failure to submit a court endorsed copy of your divorce decree(s) will cause a delay in the processing of your refund. See page 2.*

Section II: Distribution Options (Direct deposits not allowed)

☐ I elect to have my contributions mailed directly to me at the address listed above. I understand that 20% federal tax will be withheld from the taxable portion of this distribution. I may also be subject to an additional 10% penalty tax if my age is under 59½ at the time of refund.

☐ I elect a direct rollover of all my pre-tax contributions plus interest to the qualified trust plan listed below. Any monies not designated for transfer will be mailed to me. IRA Eligible Qualified Plan

☐ I elect a partial rollover of my pre-tax contributions plus interest to the qualified trust plan listed below. Any monies not designated for transfer will be mailed to me. Federal income tax will not be withheld from the portion of the distribution that is transferred and the balance I receive is subject to 20% federal withholding.

- Percentage to transfer: __________% (The percentage indicated will be applied to all subsequent refunds. Request to rollover into accounts outside the United States cannot be honored.)

Financial Institution Information: (provide only when requesting a rollover)

Financial Institution: ______________________________ **Account Number**: ______________
(up to 30 characters only)

Mailing Address: ______________________________
City **State** **Zip**

I waive the Federal 30 day waiting period and request payment as soon as administratively possible. (*This does not mean you will receive your refund in 30 days. Your refund will be processed as soon as administratively possible. This could be 90 days after initial request. See page two (2) instructions.*)

Section III: Member Signature **(PLEASE SIGN IN THE PRESENCE OF A NOTARY PUBLIC)**

____
Member Signature **Date**

Notary Stamp

Notary Public
State of _______, **County of**: ______________ **Signed before me by** ______________________ **on the day** _____ **of** __________, **20** _____.

____
Notary Public **My Commission Expires**

Section IV: Spousal Consent (PLEASE SIGN IN THE PRESENCE OF A NOTARY PUBLIC)

I hereby certify that I am the spouse of the above named Member and that I freely consent to the request for refund and/or rollover made herein.

____
Spouse Signature **Date**

Notary Stamp

Notary Public
State of _______, **County of**: ______________ **Signed before me by** ______________________ **on the day** _____ **of** __________, **20** _____.

____
Notary Public **My Commission Expires**

Section V: Employer Certification (Mandatory if you were employed within the last 90 days.)

This is to certify that the above employee terminated employment with ____________________ on __________ and that final earnings will be reported on the monthly report ending ______________. *(Should not extend beyond one (1) month following termination date.)*

Authorized By: ______________________ **Signature**: ______________________ **Date**: ______________
(print name)

New Mexico Educational Retirement Board (NMERB)
P.O. Box 26129
Santa Fe, NM 87502-0129
Phone: (505) 827-8030 / Fax: (505) 827-1855

Request for Contribution Refund Instructions – Page 2

If you wish to withdraw your member contributions plus interest, you must terminate your employment and submit a Request for Refund and/or Rollover Application to each of your current employer(s). If you terminated employment more than three months ago, you may submit the application directly to NMERB. Please do not use white out. Copied, faxed or emailed applications are not accepted—please send original document. ***If you were divorced or legally separated after receiving any NMERB service credit, you must submit a release of claims from your ex-spouse, documents that indicate that your retirement is your sole and separate property, a Qualified Domestic Relations Order that divides your NMERB benefits, or a court document that indicates that your divorce was prior to earning any NMERB service.**

Please check your application for accuracy. You must select one of the options from Section II: Direct Refund, Direct Rollover or Direct Partial Rollover. If you select a rollover to another qualified plan you must include your financial institution's information and an account number. If you wish to have your refunds processed as soon as administratively possible and waive the Federal 30 day waiting period, please check the appropriate box. Both you and your spouse, if you are married, must sign this form in the presence of a notary public in Sections III and IV. This process may take up to 90 days from initial request.

New NMERB Retirement Eligibility Rules
After you receive a full refund of your member contributions, you will have no service credit. If you later rejoin the NMERB, you will be subject to the most recent retirement eligibility rules.

Summary of IRS Regulations on Periodic Distributions

Contributions made before July 1, 1983 and payments made to purchase service have already been taxed and are therefore ***non-taxable*** when distributed from your account; these contributions are not eligible for a Direct Rollover. Contributions since July 1, 1983 and total interest earned have been taxed deferred and ***are taxable*** when distributed; the taxable balance is eligible for a *rollover* and all or any portion of your account balance can be taken as a *direct refund* or as a *direct rollover.* A rollover is a tax free transfer of an eligible distribution from one qualified employer retirement plan directly to another qualified plan or to an Individual Retirement Arrangement (IRA).

If you choose a direct refund:
Tax deferred contributions and accumulated interest credited to your account are taxed upon withdrawal. The Internal Revenue Service (IRS) requires NMERB to withhold 20% from your refund if you do not rollover the funds to a qualified retirement plan or IRA. In addition, the IRS imposes a special penalty tax on early distributions, such as a lump sum distribution, received before the plan participant reaches age 59½. This special penalty tax of 10% of the taxable portion of the distribution is applied in addition to the regular income tax.

If you choose a direct rollover:
The taxable balance of your contributions and interest are not taxed in the current year and no income tax is withheld. Your refund will be made directly to the IRA or qualified plan you identify on your refund application. Your refund will be taxable when you take it out of the IRA or qualified plan. You may select to rollover any portion (percentage) of your taxable balance. The portion of the taxable balance you receive as direct refund will be taxed in the year in which you receive payment.

The federal income tax withholding rate of 20% applies to eligible distributions made from a qualified retirement plan, such as NMERB. This tax shall be withheld on any eligible distribution made to a member, the member's surviving spouse or to an alternate payee if it is not rolled over directly into another qualified or IRA.

This message summarizes the Internal Revenue Code (IRC) rollover rules and is not intended as tax advice. To determine how IRC rollover rules apply to your situation, we suggest that you consult with a qualified tax professional for advice. Please note the 20% mandatory federal tax withholding is the responsibility of the NMERB. Any further tax liability is the sole responsibility of the member.