MOSQUERO MUNICIPAL SCHOOLS

"Students are our Number 1 Priority!"
P.O. Box 258 * 43 McNeil
Mosquero, NM 87733
Telephone: (575) 673-2271 Fax: (575) 673-2305

Employee:

Name:

Address:

- ☐ Application for employment
- ☐ Current Contract
- ☐ Transcript ☐ Degree? _____
- ☐ Copy of current driver's license/ID
- ☐ Copy of Social Security card
- ☐ Copy of PED Licenses
  1. _____ (Type of License) Expiration: _____
  2. _____ (Type of License) Expiration: _____
  3. _____ (Type of License) Expiration: _____
- ☐ Copy of background check
- ☐ W-4
- ☐ I-9 ☐ Driver's License ☐ SS Card ☐ Birth Certificate
- ☐ ERB Form ☐ ERB Beneficiary Form 42
- ☐ Direct Deposit Form
- ☐ One of the following:
  - ☐ NM Public Schools Insurance Authority (NMSPIA) Health Insurance Application (if you would like health insurance through the school)
  - ☐ ACA Waiver of Coverage Form (if you do not have health insurance through the school)
- ☐ NMPSIA Life Insurance ☐ Beneficiary Form Schedule A ($50,000 paid by school)

Mosquero Municipal Schools

P.O. Box 258 • 43 McNeil Avenue • Mosquero, New Mexico 87733
Office: (575) 673-2271 • Fax: (575) 673-2305

APPLICATION FOR EMPLOYMENT

The Mosquero Municipal Schools' Board of Education is an Equal Opportunity Employer. The Board of Education considers applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

PERSONAL INFORMATION:

NAME: _____
Last First Middle

ADDRESS: _____
Physical/P.O. Box City State Zip Code

TELEPHONE: _____
Home # Cell # Best time/day to contact you

Are you currently employed? ☐ Yes ☐ No If yes, may we contact your current employer? ☐ Yes ☐ No

If yes, please provide employer's contact information: _____
Employer Name Phone #

Are you available for an interview? ☐ Yes ☐ No If yes, when? _____

If hired, when would you be available to start work? _____

Are you prevented from lawfully being employed in this country because of Visa or Immigration status? ☐ Yes ☐ No

EDUCATION: *Please include copies of transcripts and current licenses held.

	NAME OF INSTITUTION:	CITY/STATE:	GRADUATE?	
HIGH SCHOOL			☐ Yes ☐ No	DATES ATTENDED: _____
COLLEGE LIST IF NEEDED.	1.		☐ Yes ☐ No	DATE DEGREE COMPLETED: _____ DEGREE OF: _____
	2.		☐ Yes ☐ No	DATE DEGREE COMPLETED: _____ DEGREE OF: _____
	3.		☐ Yes ☐ No	DATE DEGREE COMPLETED: _____ DEGREE OF: _____
OTHER (MILITARY, ETC.)				DATES ATTENDED: _____

EMPLOYMENT HISTORY: List in order of most recent employment first.

Employer: ____
Name City State Phone #
Job Title: ______________________ Dates Employed: ____________ to ____________
Supervisor's Name: ____
Duties: ____
Reason for Leaving: ____

Employer: ____
Name City State Phone #
Job Title: ______________________ Dates Employed: ____________ to ____________
Supervisor's Name: ____
Duties: ____
Reason for Leaving: ____

Employer: ____
Name City State Phone #
Job Title: ______________________ Dates Employed: ____________ to ____________
Supervisor's Name: ____
Duties: ____
Reason for Leaving: ____

Employer: ____
Name City State Phone #
Job Title: ______________________ Dates Employed: ____________ to ____________
Supervisor's Name: ____
Duties: ____
Reason for Leaving: ____

Employer: ____
Name City State Phone #
Job Title: ______________________ Dates Employed: ____________ to ____________
Supervisor's Name: ____
Duties: ____
Reason for Leaving: ____

LICENSES: LIST LICENSES AND EXPIRATION DATE.

LICENSE:	EXPIRATION DATE:

REFERENCES: ONLY INCLUDE REFERENCES WHO ARE FAMILIAR WITH YOUR WORK ABILITY.

NAME:	ADDRESS:	PHONE #:	PROFESSIONAL RELATIONSHIP:

ADDITIONAL INFORMATION: SHARE ANY ADDITIONAL INFORMATION YOU FEEL MAY BE HELPFUL TO US WHEN CONSIDERING YOUR APPLICATION.

AGREEMENT:

As an applicant for a position with Mosquero Municipal Schools, I have been asked to furnish information for use in reviewing my background and qualifications. I hereby authorize Mosquero Municipal Schools to investigate my past and present work, character, education, military and police records to ascertain any and all information which may be pertinent to my employment qualifications. I agree to cooperate in such investigation and release from all liability or responsibility all persons and corporations requesting or supplying such information. In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge.

Signature of Applicant: _____ Date: _____

ATTACHMENTS:

Please include a resume, copies of transcripts, copies of certificates held, and letters of reference.

Received in MMS office by _____ **Date:** _____

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Mosquero, NM 87733
Telephone: (575) 673-2271 Fax: (575) 673-2305

DIRECT DEPOSIT FORM

Employee Name: _____
First M.I. Last

Social Security #: _____

Bank Name: _____

Routing #: _____

Account #: _____

* Please attach a copy of a check or a voided check.

_____ _____

Signature of Employee **Date**

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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AFFORDABLE CARE ACT
WAIVER OF COVERAGE FORM

Having met the eligibility requirements, you are being offered the opportunity to enroll in health coverage offered by MOSQUERO MUNICIPAL SCHOOLS. You have the right to decline, or waive coverage.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA. I understand the consequences of my waiver of coverage.

_____

Name of Employee

_____ _____

Signature of Employee Date

_____

As a representative of the Employer, I received this Waiver of Coverage from the above employee on _____ (Date).

_____

Signature of the Employer Representative

READ INSTRUCTIONS BEFORE COMPLETING

Beneficiary Designation—Form 42

Form must be filled out using blue or black ink only. Copies and/or Forms with white-out will be rejected.

~ **Complete Section II or III.** Do not complete both. ~**See instructions.**

Return completed form(s) to: PO Box 26129 Santa Fe, NM 87502-0129 **1(866)691-2345 or (505) 827-8030**

Section I: Member Information Please check: ☐ New Form ☐ Beneficiary Change ☐ Male ☐ Female

SMITH (Last Name) JOHN (First Name) OPTIONAL (Previous Name (if applica)

Choose ONE Option

1234 Main Street (Address) Santa Fe (City) NM (State) 87505 (Zip)

123-456-0000 (Social Security Number) Main Street School (Employer)

Choose ONE Option

Date of Birth 01/01/1965 Telephone Number 555-123-3456

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

Section II: Beneficiary Information: By listing a beneficiary in section II, you are hereby giving your beneficiary the option to select a lifetime benefit (Option B coverage) or a one-time lump sum payment upon your death. (If you select this option, you can only name one beneficiary and it must be a human being, not a trust.)

Name: Cannot be a trust Social Security Number:

Relationship: Spouse, daughter, son, etc. Date of Birth

Beneficiary Address: Telephone Number:

City: State: Zip:

Choose only ONE option. Forms with both options selected out will be rejected. All fields are mandatory for the option you choose.

Select either Section II or Section III

Section III: Beneficiary Information: The beneficiary listed in Section III will receive a one-time lump sum payment. By listing a beneficiary in section III you hereby **reject Option B** coverage, as described in 22-11-29 (F), and your beneficiary **will not** receive a lifetime monthly benefit upon your death.

Name: CAN be a trust Social Security Number:

Relationship: Spouse, daughter, son, organization, etc. Date of Birth

Beneficiary Address: Telephone Number:

City: State: Zip:

Percentage allocation: (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

To name **multiple beneficiaries** (Section III ONLY), see Addendum on 3rd page.

Section IV: Member Authorization

I hereby declare that all of the information provided is true and complete to the best of my knowledge.

Member Signature REQUIRED Date

☐ **Check here if you are married and designating someone other than your spouse as a Beneficiary.**

Mandatory: If you are married and designating someone other than your spouse, this portion MUST be signed by your spouse in the presence of a Notary Public. Failure to do so will result in an incomplete and returned form.

Section V: Spousal Consent: *I hereby certify that I am the spouse of the above named Member; and that I have read the Designation of Beneficiary form as completed and signed by my spouse; and I hereby freely consent to the beneficiary designation made herein. I understand beneficiary payment, if any, will be made to such beneficiary or beneficiaries named on this form.*

Spouse Signature Date

A Notary is REQUIRED for designating someone other than your spouse!

Notary Stamp

Notary Public

State of , County of:

Subscribed and sworn to before me by on the day of , 20 .

Notary Public My Commission Expires

ERB

Beneficiary Designation—Form 42
Addendum

If attached, your spouse (if married) MUST sign in presence of a Notary Public.

This Section is ONLY if you have multiple beneficiaries. They will NOT receive a lifetime benefit.

Member Name: John Smith (your name) **Member SSN:** 123-456-0000

Section III (a): Beneficiary Information Use this form if you are **rejecting** the Automatic Option B coverage for your beneficiary and wish to list more than one beneficiary to receive a lump sum payment upon your death.

Name:______ Social Security Number: ______
Relationship:______ Date of Birth ______
Beneficiary Address:______ Telephone Number: ______
City:______ State:______ Zip:______
Percentage Allocation:______ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Name:______ Social Security Number: ______
Relationship:______ Date of Birth ______
Beneficiary Address:______ Telephone Number: ______
City:______ State:______ Zip:______
Percentage Allocation:______ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Name:______ Social Security Number: ______
Relationship:______ Date of Birth ______
Beneficiary Address:______ Telephone Number: ______
City:______ State:______ Zip:______
Percentage Allocation:______ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Section IV(a): Member Authorization

I hereby declare that all of the information provided is true and complete to the best of my knowledge.

______ REQUIRED ______
Member Signature Date

☐ **Check here if you are married and designating someone other than your spouse as a Beneficiary.**

Mandatory: If you are married, and designating someone other than your spouse, this portion MUST be signed by your spouse in the presence of a Notary Public. Failure to do so will result in an incomplete and returned form.

Section V(a): Spousal Consent: *I hereby certify that I am the spouse of the above named Member; and that I have read the Designation of Beneficiary form as completed and signed by my spouse; and I hereby freely consent to the beneficiary designation made herein. I understand beneficiary payment, if any, will be made to such beneficiary or beneficiaries named on this form.*

______
Spouse Signature Date

A Notary is REQUIRED for designating someone other than your spouse!

Notary Stamp

Notary Public

State of______, County of: ______

Subscribed and sworn to before me by______ on the day______ of______, 20______.

______ ______
Notary Public My Commission Expires

Rev. 10/20

ERB
P.O. Box 26129
Santa Fe, NM 87502-0129
Phone: (505) 827-8030 / Fax: (505) 827-1855

Instructions for Beneficiary Designation—Form 42

Form must be filled out using blue or black ink only. Copies and/or Forms with white-out will be rejected.

Do NOT complete if retired.

Failure to comply with the instructions will result in an incomplete and rejected form.

Active and inactive (non-retired) members covered by the New Mexico Educational Retirement Board must complete NMERB Form 42 to designate a beneficiary for their account.

See Section 22-11-2 (E) and 22-11-29 (F)(G) & (I) NMSA 1978 and Paragraph (E) & (F) of 2.82.5.13 and Paragraph (B) of 2.82.3.10 NMAC.

- Complete Sections I, II **or** III and IV. If you are married, and designated someone other than your spouse, Section V **MUST** be completed and signed by your spouse in the presence of a notary public. If section V is completed, a notary must notarize this section. Incomplete and/or incorrect forms will be returned to you.

  ⇒ **Section II Beneficiary Information Automatic Option B coverage**: If you are vested (five or more years of earned service credit) and die prior to retirement, your named beneficiary may select either a monthly lifetime benefit (annuity) or a one-time lump sum payment. You can name only one beneficiary for Option B coverage. Naming more than one beneficiary on this form automatically rejects the Option B coverage. Only a named beneficiary may select the monthly benefit option, all other beneficiaries are only eligible for a one-time lump sum payment.

  ⇒ **Section III Beneficiary(ies) Information**: If you opt out of Option B coverage and die prior to retirement, your named beneficiary(ies) on this form will receive a one-time lump sum payment.

- Complete Section II if you want your beneficiary to qualify for the Option B coverage, as described in §22-11-29 (F) NMSA 1978. Once you are vested (five or more years of earned service credit) and if you die prior to retirement your named beneficiary will have the choice to either receive a monthly lifetime benefit or a one-time lump sum payment. If you die prior to having earned five years of service credit, your named beneficiary will receive a one-time lump sum payment.

- Complete Section III if you reject the Option B coverage, as described in 22-11-29 (F), for your beneficiary or want to name more than one beneficiary. Please note that naming more than one beneficiary automatically rejects the Option B coverage for your beneficiaries. **If you want to name more than one beneficiary, you may complete the Beneficiary Designation —Form 42 Addendum.**

- Please include any previous names you have had if applicable.

- Beneficiary(ies) may be changed any time prior to retirement.

- In the event of a divorce it is important that you review your existing Beneficiary Designation form to ensure that the desired beneficiary(ies) are named. A divorce does not automatically remove your former spouse as your beneficiary. The Beneficiary Designation Form-42 can be accessed at *www.nmerb.org/downloadableforms*. *** Please be advised that beneficiary selections are subject to any court orders regarding the division of the community property portion of your retirement benefit due to divorce. Provide a divorce decree, if you divorced at any point during your NMERB service.**

- If you have never earned prior NMERB service and you complete this Beneficiary Designation-Form 42 and are not reported by any NMERB covered employer within 90 days, this form will be void and will be returned to you.

- **Upon employment with an NMERB covered entity**, this form must be returned to the NMERB.

- **If you fail to submit a valid beneficiary designation form, any benefits payable upon your death will be paid to your surviving spouse or domestic partner, or if none, in a one-time lump sum payment to your estate. Proof of marital status or domestic partnership is required.**

READ INSTRUCTIONS BEFORE COMPLETING

Beneficiary Designation—Form 42

Form must be filled out using blue or black ink only. Copies and/or Forms with white-out will be rejected.

~ Complete Section II or III. Do not complete both. **~See instructions.**

Return completed form(s) to: PO Box 26129 Santa Fe, NM 87502-0129 **1(866)691-2345 or (505) 827-8030**

Section I: Member Information Please check: ☐ New Form ☐ Beneficiary Change ☐ Male ☐ Female

Last Name _____ First Name _____ Previous Name (if applicable) _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Employer _____

Date of Birth _____ Telephone Number _____

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

Select either Section II or Section III

Section II: Beneficiary Information: By listing a beneficiary in section II, you are hereby giving your beneficiary the option to select a lifetime benefit (Option B coverage) or a one-time lump sum payment upon your death. (If you select this option, you can only name one beneficiary and it must be a human being, not a trust.)

Name: _____ Social Security Number: _____

Relationship: _____ Date of Birth _____

Beneficiary Address: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

Section III: Beneficiary Information: The beneficiary listed in Section III will receive a one-time lump sum payment. By listing a beneficiary in section III you hereby **reject Option B** coverage, as described in 22-11-29 (F), and your beneficiary **will not** receive a lifetime monthly benefit upon your death.

Name: _____ Social Security Number _____

Relationship: _____ Date of Birth _____

Beneficiary Address: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

Percentage allocation: _____ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Section IV: Member Authorization

I hereby declare that all of the information provided is true and complete to the best of my knowledge.

Member Signature _____ Date _____

☐ **Check here if you are married and designating someone other than your spouse as a Beneficiary.**

Mandatory: If you are married and designating someone other than your spouse, this portion MUST be signed by your spouse in the presence of a Notary Public. Failure to do so will result in an incomplete and returned form.

Section V: Spousal Consent: *I hereby certify that I am the spouse of the above named Member; and that I have read the Designation of Beneficiary form as completed and signed by my spouse; and I hereby freely consent to the beneficiary designation made herein. I understand beneficiary payment, if any, will be made to such beneficiary or beneficiaries named on this form.*

Spouse Signature _____ Date _____

Notary Stamp

Notary Public

State of _____, County of: _____

Subscribed and sworn to before me by _____ on the day _____ of _____, 20_____.

Notary Public _____ My Commission Expires _____

Beneficiary Designation—Form 42

Addendum

ERB

If attached, your spouse (if married) MUST sign in presence of a Notary Public.

Member Name: ______________________ **Member SSN:** ______________________

Section III (a): Beneficiary Information Use this form if you are **rejecting** the Automatic Option B coverage for your beneficiary and wish to list more than one beneficiary to receive a lump sum payment upon your death.

Name: ______________________ Social Security Number: ______________________
Relationship: ______________________ Date of Birth ______________________
Beneficiary Address: ______________________ Telephone Number: ______________________
City: ______________________ State: ______________________ Zip: ______________________
Percentage Allocation: __________ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Name: ______________________ Social Security Number: ______________________
Relationship: ______________________ Date of Birth ______________________
Beneficiary Address: ______________________ Telephone Number: ______________________
City: ______________________ State: ______________________ Zip: ______________________
Percentage Allocation: __________ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Name: ______________________ Social Security Number: ______________________
Relationship: ______________________ Date of Birth ______________________
Beneficiary Address: ______________________ Telephone Number: ______________________
City: ______________________ State: ______________________ Zip: ______________________
Percentage Allocation: __________ (If no percentage is indicated the proceeds will be split evenly among those beneficiaries named.)

Section IV(a): Member Authorization

I hereby declare that all of the information provided is true and complete to the best of my knowledge.

______________________ ______________________
Member Signature Date

☐ **Check here if you are married and designating someone other than your spouse as a Beneficiary.**

Mandatory: If you are married, and designating someone other than your spouse, this portion MUST be signed by your spouse in the presence of a Notary Public. Failure to do so will result in an incomplete and returned form.

Section V(a): Spousal Consent: *I hereby certify that I am the spouse of the above named Member; and that I have read the Designation of Beneficiary form as completed and signed by my spouse; and I hereby freely consent to the beneficiary designation made herein. I understand beneficiary payment, if any, will be made to such beneficiary or beneficiaries named on this form.*

____
Spouse Signature Date

Notary Stamp

Notary Public

State of ______________________, County of: ______________________

Subscribed and sworn to before me by ______________________ on the day _____ of __________, 20 _____.

______________________ ______________________
Notary Public My Commission Expires

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 Cvrg Eff. Date (mm/dd/yyyy)

District/Entity Name	District/Entity #

New Mexico Public Schools Insurance Authority

New Mexico Public Schools Insurance Authority
EMPLOYEE ENROLLMENT APPLICATION

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

1 Social Security Number	Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)

Mailing Address	City	State	Zip Code	Home Phone Number

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

2 ENROLLMENT STATUS ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

3 ENROLLMENT **Elect your coverage offered by your employer**

☒ BASIC LIFE: The Standard (Paid in full by employer. Complete Schedule A Beneficiary Form)

MEDICAL:

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

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

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

☐ Decline Medical. Reason for declining coverage: _____

Are you eligible for Medicaid? ☐ Yes ☐ No

DENTAL: ☐ **Delta Dental** ☐ High Option Plan *(Default)* ☐ Low Option Plan

☐ **United Concordia** ☐ High Option Plan *(Default)* ☐ Low Option Plan

☐ Decline Dental

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

☐ Decline Vision

☐ **LONG TERM DISABILITY: The Standard**

☐ Decline Long Term Disability

☐ **ADDITIONAL LIFE: The Standard** *(Complete Schedule A Beneficiary Form)* Select: ☐ 1X ☐ 2X ☐ 3X Base Annual Salary ☐ Spouse Life ☐ Child Life

☐ Decline Employee Additional Life
☐ Decline Dependent Life

4 DEPENDENT INFORMATION List all dependents you wish to enroll. **Indicate an A (add) or N/A (not applicable) for all names listed below.**

Please provide requested information for additional dependents on separate sheet if necessary.

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, or Court Order Attached
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No

5 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 DATE OF HIRE

6 EMPLOYER CERTIFICATION ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. 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 their eligibility for benfits 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.

New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

SCHEDULE A – BENEFICIARY ASSIGNMENT

Employee Social Security Number	Employee Name	School District/Employer
Mailing Address:		Date of Birth (in mm/dd/yyyy format)

Primary Beneficiary:

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Secondary Beneficiary **(in the event the primary beneficiary is not living at the time of the insured's death):**

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

STATEMENT OF MARITAL STATUS (check one)

☐ I AM NOT MARRIED. I understand that if I marry, it will affect my right to dispose of community property, and that I should then review my beneficiary designation.

☐ I AM MARRIED. My spouse is the Primary Beneficiary and/or is designated to receive 50% or more of my benefit.

☐ I AM MARRIED. My spouse is not the Primary Beneficiary and/or is designated to receive less than 50% of my benefit.

EMPLOYEE SIGNATURE _____ **DATE:** _____

Witnessed by Employer: _____ **DATE:** _____

IMPORTANT NOTE: Community Property Laws are applicable to employees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin; therefore, a spouse has property interest in insurance provided to the employee through his/her employment.

RETURN TO YOUR EMPLOYER'S BENEFIT OFFICE

10/10/2014

Employee Data Form

Must be completed by the Employee and Certified by the Employer

Employer must provide a copy to NMERB
Fax to 505-827-8010

Name:		SSN:	☐ M ☐ F
DOB:	Phone:	Email:	

By supplying NMERB with your Email you are agreeing to receive emails from NMERB. Your Email will not be shared or sold.

Mailing address:		
City:	State:	Zip:

Active Member:

☐ **New Hire:** I have never been employed by a public school, charter school, university or college, or other NMERB affiliated employer in NewMexico.

☐ **Re-Hire:** I am not currently employed by a public school, charter school, university or college, or other NMERB affiliated employer in New Mexico, however I have contributed to NMERB in the past.

☐ **Multiple NMERB Employers:** I am currently employed by another NMERB Employer.

Check one only for other NMERB Employer:
- ☐ Part Time
- ☐ Full Time
- ☐ ARP (College or University)

Name of other NMERB Employer:

NMERB Retiree:

☐ I am retired through the New Mexico Educational Retirement Board.

Check one:
- ☐ I am approved under the Return to Work Program and will provide my employer with either an NMERB RTW Approval letter (approval prior to 7/1/2019) or a copy of my approved NMERB RTW Application (approval on or after 7/1/2019).
- ☐ I am approved for Working .25 FTE or Less and will provide my employer with a copy of my approved NMERB RTW Application.
- ☐ I am approved for Earning Less than $15,000 and will provide my employer with a copy of my approved NMERB RTW Application.

NMPERA Retiree:

☐ I am retired from the New Mexico Public Employees Retirement Association. I will provide documentation of this to the employer.
(If you are retired from a PERA system from a state other than New Mexico, you are identified as an Active Member in the NMERB system)

Name Change: Previous Name: _____
Last First Initial

*Upon receipt of your first paystub from your employer, verify that your SSN is correct on the paystub and that the NMERB contributions were deducted by your employer.

Employee Signature: _____ **Date:** _____

EMPLOYER CERTIFICATION

This is to certify that the above person is employed in the Position of: _____

Start Date: _____ District/University: _____

Revised 5/20 Authorized Signature: _____ Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . 4(c) $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)