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)
- ☐ New hire reporting (business office)
- ☐ Entered in Skyward (Secretary)

Mosquero Municipal Schools

P.O. Box 258 • 43 McNeil Avenue • Mosquero, New Mexico 87733
Office: (575) 338-4653 • 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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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 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) _____
- ☐ 4. An alien authorized to work until _____ (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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, sex, 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, sex, 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
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		**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		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with “RE” notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

2025

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 surviving spouse**
☐ **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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

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 ENROLLMENT / CHANGE FORM

This form is Effective 1/1/2025.

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

District/Entity Name	District/Entity #

RESET FORM

1

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

Mailing Address	City	State	Zip Code	Home Phone Number

Marital Status	Gender	E-Mail Address Mandatory (Do not block emails from **no-reply@easipta.com**)	Work Phone Number	Cell Phone Number
☐ S ☐ M	☐ F ☐ M			

REASON FOR CHANGE (Answer questions below):

What event took place? _____ ☐ New Hire (enrolling within 31 days of hire) ☐ Evidence of Insurability

What date did event take place? _____ ☐ Qualifying Event (enrolling within 31 days of event)

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 / DEPENDENTS** ☐ **CANCEL COVERAGE / DEPENDENTS**

BASIC LIFE: The Standard ☐ **Decline Free Basic Life**

MEDICAL:

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

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

☐ Decline Medical

Reason: _____

Eligible for Medicaid? ☐ Yes ☐ No

DENTAL: ☐ **Blue Cross Blue Shield of NM Dental (Default)** ☐ High Option ☐ Low Option ☐ **United Concordia** ☐ High Option ☐ Low Option ☐ **Delta Dental** ☐ High Option ☐ Low Option ☐ Decline Dental

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

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

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

3 DEPENDENT INFORMATION

List all dependents you wish to enroll. Provide requested information for additional dependents on separate form.
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) **(REQUIRED)**	Gender **(REQUIRED)**	Dependent's Relationship to You **(REQUIRED)**	Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached **(REQUIRED)**
							☐ 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.**

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

EMPLOYEE SIGNATURE _____ DATE _____

5 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	Date Variable Hour Employee became eligible for **medical only** coverage	Date Received in Your Office
	$					

EMPLOYER BENEFITS SPECIALIST SIGNATURE: **DATE:**

Revised August 2024

Please read the NMPSIA Program Guide as you complete this form.

NMPSIA's Program Guide outlines the NMPSIA Eligibility Rules and administrative guidelines for enrollment.

ELIGIBILITY

If you are enrolling as a New Hire or if you are reporting a change in status, you must turn in this form within 31 days form your 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 medical benefits with their Employee Benefits Office.

Basic life insurance coverage is effective the first day of the month following your date of hire 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. 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 themselves, 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 DESIGNATION FOR LIFE COVERAGE

Go to Employee Login to make your designation 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.

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

AFFORDABLE CARE ACT (ACA)
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

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: (855)214-0835
Mail to: NMERB, PO Box 26129, Santa Fe ,NM 87747

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 RTW Program 60 Months with a 90-day layout. Effective 07/01/2025.
- ☐ I am approved under the RTW Program 12-month layout.
- ☐ I am approved RTW Program Less Than $25,000 with a 90-day layout. Effective 07/01/2025
- ☐ I am approved RTW Program .25FTE or less (FTE is combined with multiple employers)

All NMERB Retirees

☐ I have provided a copy of my approved Return-to-Work documentation to my employer.

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: _____

Obtained Proof from the NMERB Retiree of their Approved RTW status: ☐

Authorized Signature:_____ **Date:**_____

Pre-Retirement Beneficiary Designation Form

Member to mail completed form to address below

MEMBER INFORMATION

☐ New designation ☐ Change designation

Name (First, Middle, Last) | Last 4 digits of SSN XXX–XX– | Gender ☐ M ☐ F

Mailing address

City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Employer

Marital status (Required – check ☒ one)

☐ Never married ☐ Married _____ (mm/dd/yyyy) ☐ Married, previously divorced ☐ Divorced ☐ Widowed

I am approved for NMERB disability retirement: ☐ No ☐ Yes

BENEFICIARY DESIGNATION

1. I am married and designating someone other than my spouse as a Beneficiary ☐ No ☐ Yes, see **Spousal Consent**
2. I elect to provide my designated beneficiary(ies) listed below (check ☒ only one coverage option):

☐ **Option B Coverage**: My beneficiary will have the option to select a lifetime benefit or a one-time lump sum payment upon my death. *You can only name one beneficiary (a living person or Special Needs Trust), not an organization.*

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you

☐ **No Option B Coverage**: My beneficiary(ies) will receive a one-time lump sum payment upon my death. I reject Option B coverage, as described in 22-11-29(J).

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you | % allocation

List additional beneficiaries on page 2.

MEMBER AUTHORIZATION

I hereby authorize the NMERB to change my address as indicated above and hereby declare that all of the information provided on this page is true and complete to the best of my knowledge.

X _____ _____

Member's signature | Date (mm/dd/yyyy)

New Mexico Educational Retirement Board (NMERB)
P.O. Box 26129, Santa Fe, New Mexico 87502-0129
Phone: (505) 827-8030 or toll-free 1 (866) 691-2345

Rev 06/23

Pre-Retirement Beneficiary Designation Form

Member to mail completed form to address below

☐ **No Option B Coverage** (continued from page 1)

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you | % allocation

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you | % allocation

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you | % allocation

SPOUSAL CONSENT TO WAIVE ENTITLEMENT

I hereby certify that I am the spouse of the above-named Member and have read this Beneficiary Designation form as completed and signed by my spouse. 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.

X _____ _____

Spouse's signature | Date (mm/dd/yyyy)

Witnessed in the presence of a Notary Public

State of _____ County of _____

Notary Stamp

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

X _____ _____

Notary public signature | My commission expires (mm/dd/yyyy)

MEMBER AUTHORIZATION

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

X _____ _____

Member's signature | Date (mm/dd/yyyy)

New Mexico Educational Retirement Board (NMERB)
P.O. Box 26129, Santa Fe, New Mexico 87502-0129
Phone: (505) 827-8030 or toll-free 1 (866) 691-2345

Rev 06/23

Pre-Retirement Beneficiary Designation Form

Member to mail completed form to address below

INSTRUCTIONS

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

2. Form must be filled out using black or blue ink only. Your beneficiary designation request will be rejected if the NMERB receives a copy, email, or fax of the form, and/or if the form contains white-out.

3. 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.

4. If you are married and designating someone other than your spouse, the Spousal Consent portion of the form **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.

5. **Option B Coverage Beneficiary:** If you have worked for five or more years and pass away before retiring, your chosen beneficiary has the option to receive either a monthly lifetime benefit (annuity) or a one-time lump sum payment. However, if you pass away before accumulating five years of service credit, your beneficiary will receive a one-time lump sum payment. It's important to note that you can only designate one beneficiary for Option B Coverage, as explained in §22-11-29 NMSA 1978. If you intend to name a Special Needs Trust, please provide proof of the beneficiary's age, along with the required Legal Trust Documentation. Please be aware that designating more than one beneficiary for this option will result in your request being rejected.

6. **No Option B Coverage Beneficiary(ies):** If you reject Option B Coverage, as described in §22-11-29 (J) NMSA 1978, and die before your retirement, your named beneficiary(ies) will receive a one-time lump sum payment. If you have named multiple beneficiaries and no percentage is indicated, the proceeds will be split evenly among those named beneficiaries.

7. You can change your beneficiary(ies) and Option B coverage any time **before** your retirement. If you are currently receiving a disability benefit, at age 60, your status changes to retired at which time you may elect an optional benefit

8. In the event of a divorce it is important that you review your existing beneficiary designation to ensure that your desired beneficiary(ies) are named. A divorce does not automatically remove your former spouse as your plan beneficiary. Fill out and submit a new *Beneficiary Designation* form to make your desired changes.
Beneficiary selections are subject to any court orders regarding the division of the community property portion of your retirement benefit due to divorce. Provide the NMERB with a divorce decree if you divorce at any point during your NMERB participation.

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

10. Please keep a copy of this beneficiary designation for your records.

New Mexico Educational Retirement Board (NMERB)
P.O. Box 26129, Santa Fe, New Mexico 87502-0129
Phone: (505) 827-8030 or toll-free 1 (866) 691-2345

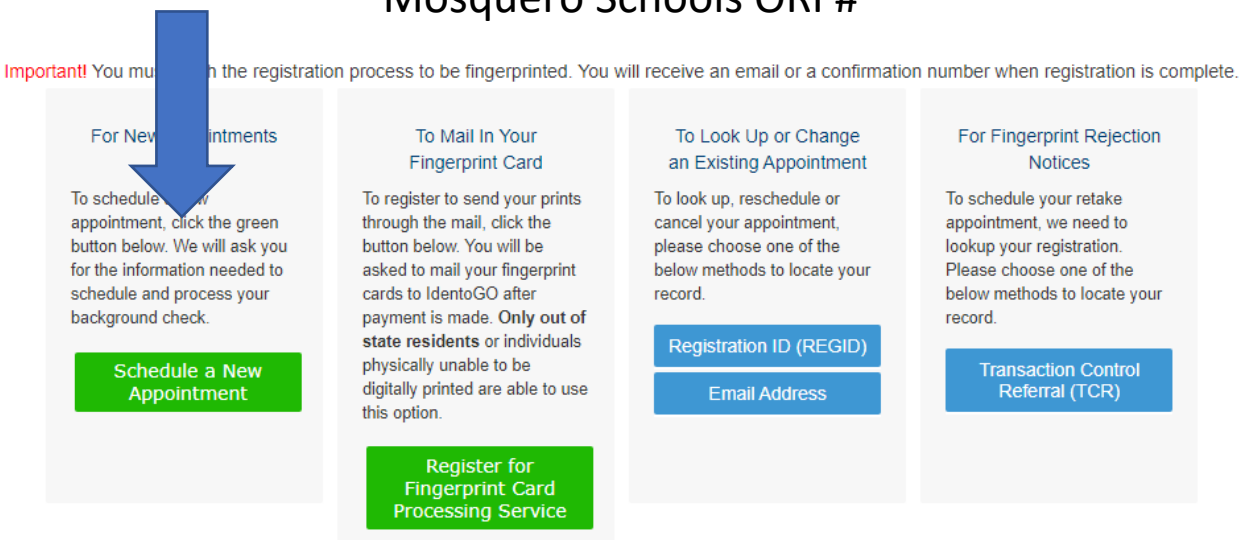
Staff Background Checks

Applicants will need to register with IdentoGO at:

https://nm.state.identogo.com/

Mosquero Schools ORI # is NM930061Z

Click Schedule new appointment and follow the prompts using Mosquero Schools ORI #



Notify Lisa within 24 hours of completion once fingerprints are taken 575-338-4653 or business.assistant@mosquero.net