ADMINISTRATIVE OFFICE OF THE COURTS
NEW EMPLOYEE ORIENTATION TRAINING & CHECKLIST

Employee: Hire Date: Employee ID:

Employee's Classification: Judicial Entity: Position #:

Hourly Rate: Annual Salary:

Pay Range: Compa Ratio:

OL Number: Full Time / Part Time (circle one)

Supervisor: Status of Position: Classified / Term / Temp / At-Will (circle one)

Status of Employee: Probationary / Non-Probationary (circle one) FLSA Status: Exempt / Non-Exempt (circle one)

Employment History: New Hire / Promotion / Transfer BU to BU / Transfer Sal Plan to Sal Plan (circle one)

Prior Employment

Have you ever worked for the State of New Mexico before?

YES NO (circle one) *If yes, what approx. dates? _____

*If dates are prior to January 2006, please provide employment verification. If previously employed with the State of NM (Judicial, Executive, or Legislative) you are responsible for notifying AOC HRD and providing documentation, which is needed to ensure you earn the appropriate leave accruals.

Did you retire from the State of New Mexico or are you receiving a pension from PERA?

YES NO (circle one)

SECTION 1 – Policy Training & Acknowledgement forms

Please initial that you received and are aware that you are responsible for reading and adhering to all New Mexico Judicial Branch Personnel Rules, Policies and Procedures, including any applicable forms effective immediately, and for the duration of your employment. You will also sign an acknowledgement form to this affect, and that it is your responsibility for complying with future changes and revisions of such Rules, Policies, Procedures, Practices, Regulations, or Guidelines.

SECTION 1 - Policy, Training & Acknowledgement forms	Incumbents Initials / AOC HRD Received	
(1.A) *New Mexico Judicial Code of Conduct and Supreme Court order 10-8500 (CLICK HERE)	_____	
(1.A.1) *Acknowledgement form for NM Judicial Branch Personnel Rules & Regulations – Definitions of Just Cause and NM Judicial Branch Personnel Policies and Supreme Court Order 21-8500-022 - Code of Conduct and Supreme Court order 10-8500 [including Training] (CLICK HERE)	_____	☐
(1.A.2) Supreme Court Order No. 23-8500-010 Rescinding Order No. 22-8500-037 (CLICK HERE)	_____	
(1.B) Driving While Intoxicated (DWI) Policy (CLICK HERE)		
(1.B.1) Driving While Intoxicated (DWI) Acknowledgement Form (CLICK HERE)	_____	☐
(1.C) *Policy for Financial Fraud Policy and Supreme Court Order 14-8500 (CLICK HERE)	_____	
(1.C.1) *Acknowledgement form for Financial Fraud Reporting and Prevention Policy [including Training] (CLICK HERE)	_____	☐
(1.D) *Policy for Drug/Alcohol Free Workplace and Drug/Alcohol Testing (CLICK HERE)	_____	
(1.D.1) *Acknowledgement form for Drug-Free and Alcohol-Free Work Place and Drug/Alcohol Testing Policies [including Training] (CLICK HERE)	_____	☐
(1.E) Workers' Compensation Policy (CLICK HERE)	_____	

*Forms completed AT New Employee Orientation
** Forms due back to AOC HRD within two weeks
Updated: 4/2/24

(1.E.1) *Acknowledgement form for Workers' Compensation Policy (CLICK HERE)	_____	☐
(1.F) *Policy for Driving with Electronics (CLICK HERE)	_____	
(1.F.1) *Acknowledgement form for Driving with Electronics Policy [including Training] (CLICK HERE)	_____	☐
(1.G) *Policy for Language Access Training (CLICK HERE)	_____	
(1.G.1) *Acknowledgement form for Language Access Training Policy [including Training] (CLICK HERE)	_____ _____	☐
(1.H) Loss Prevention and Control & FEMA Training, Video and Active Shooter "How to Respond" Acknowledgement Form (CLICK HERE)	_____	☐
(1.H.1) OSHA Training Tutorial on Portable Fire Extinguishers "Understanding Their Use and Limitations" Acknowledgment Form (CLICK HERE)	_____	☐
(1.I) Computer and Internet Use Policy and Supreme Court Order 06-8500 (CLICK HERE)	_____	
(1.I.1) *Computer and Internet Use Policy and Supreme Court Order Acknowledgement form (CLICK HERE)	_____	☐
(1.J) *Policy for Harassment, Including Sexual Harassment, Discrimination & Retaliation Prevention	_____	
(1.J.1) *Acknowledgement form for Harassment, Including Sexual Harassment, Discrimination & Retaliation Prevention Policy [including Training] (CLICK HERE)	_____	☐
(1.K) Administrative Office of the Courts Vehicle & Reimbursement Policy (CLICK HERE)	_____	
(1 K.1) Administrative Office of the Courts Vehicle & Reimbursement Acknowledgement form (CLICK HERE)	_____	☐
(1.L) *Acknowledgement form for FLSA and Overtime Compensation (CLICK HERE)	_____	☐
(1.L.1) Fair Labor Standard Act Determination Letter	_____	☐
(1.M) *Transgender Cultural Fluency Training and Google Form Acknowledgement (CLICK HERE) ***No physical form AOC HRD will verify acknowledgement on the Google form tracking log***	_____	☐
(1.N) Tuition Reimbursement Policy (CLICK HERE)	_____	
(1.N.1) Tuition Reimbursement Policy Request Form (CLICK HERE)	_____	

SECTION 2 - Personal Data forms	**Incumbents Initials / AOC HRD Received**	
(2.A) *Employment Eligibility Verification (I-9) (CLICK HERE)	_____	☐
(2.B) *Personal Data form (CLICK HERE)	_____	☐
(2.C) *Employee Withholding Allowance Certificate (W-4) form (CLICK HERE)	_____	☐
(2.D) *Direct Deposit Authorization and Agreement or Declination (CLICK HERE)	_____	☐

SECTION 3 – Public Employees Retirement Association (PERA) forms	**Incumbents Initials / AOC HRD Received**	
(3.A) *Application for PERA Membership (Membership is a condition of employment) (CLICK HERE)	_____	☐
(3.B) *Beneficiary Designation form (PERA) (CLICK HERE)	_____	☐
(3.C) *Beneficiary Spousal Consent form (PERA) (CLICK HERE)	_____	☐ N/A ☐
(3.D) PERA TIER 1 and TIER 2 Member Handbooks (CLICK HERE)	_____	
(3.E) PERA TIER 1 Summary of PERA Pension Plan Changes (CLICK HERE)	_____	
(3.F) PERA TIER 2 Summary of PERA Pension Plan Changes (CLICK HERE)	_____	

SECTION 4 - Insurance forms and Information	**Incumbents Initials / AOC HRD Received**	
(4.A) **State of NM Employee Benefits Eligibility Acknowledgement Form (CLICK HERE)	_____	☐
(4.B) **The Hartford Insurance Company State of New Mexico General Services Department Beneficiary Designation / Change form (CLICK HERE)	_____	☐
(4.C) **State of New Mexico Employee Enrollment/Change form (CLICK HERE TO ENROLL/WAIVE COVERAGE)	_____	☐

*Forms completed AT New Employee Orientation
** Forms due back to AOC HRD within two weeks
Updated: 4/2/24

(4.D) HIPAA Privacy Policies and Procedures for the Risk Management Division, GSD, SONM	_____
(4.E) *Employee Notice of Privacy Practices, Risk Management Division (HIPAA) (CLICK HERE)	_____ ☐
(4.F) **Affidavit of Domestic Partnership form (CLICK HERE)	_____ ☐ N/A ☐
(4.G) Principle Life Insurance Company Enrollment and Change Form (CLICK HERE) ***Applies to judges and attorneys only. Must complete waiver if not enrolling***	_____ ☐ N/A ☐
(4.H) **2023 Medical Flexible Spending Account (FSA) Information, 2023 Dependent Care FSA Information, 2023 Transit and Parking Benefit Information (CLICK HERE)	_____ ☐ N/A ☐
(4.I) "Maximize your income with a healthcare FSA" - Flexible Spending Account Information (CLICK HERE)	_____
(4.J) Employee FAQ: Flexible Spending Accounts Information (CLICK HERE)	_____
(4.K) *State of New Mexico Premium Only Plan "POP" Waiver form (CLICK HERE)	_____ ☐ N/A ☐
(4.L) Bi-Weekly Contribution Schedule of Insurance Premiums handout (CLICK HERE)	_____
(4.M) State of New Mexico Group Benefits Plan Year Jan-Dec Power Point handout (CLICK HERE)	_____
Summary of Benefits & Coverage:	
(4.M.1) Blue Cross Blue Shield HMO Plan Highlights (CLICK HERE)	_____
(4.M.2) Blue Cross Blue Shield PPO Plan Highlights (CLICK HERE)	_____
(4.M.3) Presbyterian HMO Plan (CLICK HERE)	_____
(4.M.4) Cigna OAP Plan (CLICK HERE)	_____
(4.M.5) Cigna OAPIN (CLICK HERE)	_____
(4.M.6) PPO New Mexico Delta Dental Plan (CLICK HERE)	_____
(4.M.7) Eye Med Vision Plan for the State of NM (CLICK HERE)	_____
(4.M.8) CVS Caremark Prescription Drug Benefit Plan (CLICK HERE)	_____
(4.M.9) State of New Mexico Health Benefits Comparison guide (CLICK HERE)	_____
(4.N) COBRA: Notice of Rights to Continue Coverage Information (CLICK HERE)	
(4.N.1) COBRA Notification Form (CLICK HERE)	_____
(4.O) FAQ`s for Employees about COBRA Continuation Health Coverage (CLICK HERE)	_____
(4.P) Employee Assistance Program Brochure (CLICK HERE)	_____
(4.Q) Deferred Compensation Enrollment Guide and Plan (CLICK HERE)	_____
(4.R) Deferred Compensation Forms (CLICK HERE)	_____
(4.S) Voluntary Benefits Enrollment (CLICK HERE)	_____
(4.T) Administrative Office of the Courts Health Benefits FAQs (CLICK HERE)	_____

SECTION 5 - Information for the employee	**Incumbents Initials / AOC HRD Received**
(5.A) New Mexico Court Structure (CLICK HERE)	_____
(5.B) Administrative Office of the Courts (CLICK HERE)	_____
(5.C) Human Resources Staff (CLICK HERE)	_____
(5.D) New Mexico State Courts Map (CLICK HERE)	_____
(5.E) Employee Calendar (CLICK HERE)	_____
(5.F) Holiday Schedule (CLICK HERE)	_____
(5.G) Benefits Worth form (CLICK HERE)	_____
(5.H) Alternative Dispute Resolution Brochure (CLICK HERE)	_____
(5.I) Overview of Benefits handout (CLICK HERE)	_____
(5.J) Computer Security "Don't Get Hooked" & "You Are a Target"(CLICK HERE)	_____
(5.K) Worksite Wellness Including Self-Care and Physical Fitness Leave Policy (CLICK HERE)	_____
(5.L) Worksite Wellness Brochure: Holistic Employee Wellness Program (CLICK HERE)	_____
(5.M) RAVE Mobile Safety Alert System (get it here!) (CLICK HERE)	_____

*Forms completed AT New Employee Orientation
** Forms due back to AOC HRD within two weeks
Updated: 4/2/24

SECTION 6 - Training (In addition to the Training acknowledged for in Section 1 of this checklist)	Incumbents Initials	
(6.A) Media Partners Training Video "How was Your Day?" Certificate (CLICK HERE)	_____	☐
(6.B) Media Partners Training Video "Once & For All" Certificate (CLICK HERE)	_____	☐
(6.C) Media Partners Training Video "Getting Real about Workplace Violence" (CLICK HERE)	_____	
(6.D) Loss Prevention and Control & FEMA Training, Video, and Active Shooter "How to Respond" (CLICK HERE)	_____	
(6.E) New Employee Orientation PowerPoint Training Presentation: (CLICK HERE)		
(6.E.1) – Training Module 1 "Structure of the Judiciary & Background on AOC"	_____	
(6.E.2) – Training Module 2 "NM Judicial Branch Rules Part 1 & 2, &NM Judicial Branch Code of Conduct"	_____	
(6.E.3) – Training Module 3 "Loss Control, Fraud Reporting, Drug & Alcohol Prevention"	_____	
(6.E.4) – Training Module 4 "Harassment, Discrimination & Retaliation Prevention"	_____	
(6.E.5) – Training Module 5 "Benefits Overview including PERA and Payroll"	_____	

COMPUTER & INTERNET USAGE ACKNOWLEDGEMENT

I understand there is no expectation of privacy on state owned equipment and that email and instant messages are kept forever and any content I sent or receive over state owned equipment may be subject to public inspection.

_____ _____

New Employee Signature Date

NEW EMPLOYEE ORIENTATION ACKNOWLEDGEMENT

I, _____, an employee of the Administrative Office of the Courts, hereby certify that I have completed the New Employee Orientation Training, Including topics outlined in this document. I certify that I have completed the required acknowledgement forms for each required policy outlined in this document. I further acknowledge that I will read and review the content from the New Employee Orientation training, that I will abide by the policies and training requirements, and that I am responsible for raising with my supervisor and/or AOC Human Resources any questions I may have regarding the training material. I further understand that my violation of any of the aforementioned NMJBPR or AOC policies may result in disciplinary action up to and including dismissal.

_____ _____

New Employee Signature Date

_____ _____

Presenter Date

*Forms completed AT New Employee Orientation
** Forms due back to AOC HRD within two weeks
Updated: 4/2/24

Administrative Office of the Courts

Supreme Court of New Mexico

Arthur W. Pepin, AOC Director
Lynette Paulman-Rodriguez, AOC HR Director

202 E. Marcy St.
Santa Fe, NM 87501
(505) 470-7205
(505) 479-2641 (fax)

ACKNOWLEDGEMENT FORM

Signed form due back to AOC/HRD or Judicial Entity's HR Professional

I,_____understand that I am responsible for reading, reviewing and
Print Name

adhering to the NM Judicial Branch Personnel Rules (NMJBPR) Part 1 for classified employees, or Part 2 for at-will employees adopted by Supreme Court Order 23-8500-005 and effective May 13, 2023.

I acknowledge my responsibility for complying with future changes and revisions of such policies, procedures, practices and regulations as they are communicated to me, and that it is my responsibility to contact my HR Professional should I have questions.

These materials are general in nature and do not address all the possible applications of, or exceptions to, these Rules, Policies, and Procedures. The Supreme Court of the state of New Mexico retains the sole right in its judgment to modify, suspend, interpret or cancel in whole or part at any time these Rules, personnel policies or practices as defined in NMJBPR Part 1 Section 1.04, and Part 2 Section 15.04 .

_____ _____
Employee's Signature Date

cc: Employee Personnel File

The New Mexico Judicial Branch Personnel Rules, general policies and the Code of Conduct or Canons are located on the nmcourts website at https://humanresources.nmcourts.gov/default.aspx under the NM Judicial Branch Personnel Rules & Policies section.

NEW MEXICO JUDICIAL BRANCH **Policy No. 2014.NMJB.85**
GENERAL PERSONNEL POLICY AND PROCEDURE:
DRIVING WHILE INTOXICATED (DWI)

DRIVING WHILE INTOXICATED (DWI) ACKNOWLEDGMENT FORM

Form 2014.NMJB.85-D

I, _____,
(*Print Name*)

acknowledge that I have received, read and understand the

New Mexico Judicial Branch
Driving While Intoxicated (DWI) Policy & Procedure,

and understand that I am responsible for adhering to these policies. I understand that I am required to report any arrest for DWI to my Court Executive Officer or Administrative Authority within seventy-two (72) hours. I understand that while the fact of arrest may not be a basis for termination, failure to report **is just cause for discipline up to and including immediate termination.** I understand that upon conviction for DWI, I must provide my Human Resources Administrator with a copy of the criminal complaint and statement of probable cause, any plea and disposition agreement entered in the case, the judgment and sentence, and the order of probation, along with signing the partial waiver form allowing my court to gain access to the treatment recommendation of the probation department or community compliance program

TO BE COMPLETED BY JUDICIAL BRANCH EMPLOYEE	
EMPLOYEE SIGNATURE:	**DATE SIGNED/COMPLETED:**
JUDICIAL ENTITY/COURT:	

cc: Employee Personnel File

NEW MEXICO JUDICIAL BRANCH

ACKNOWLEDGEMENT FORM

Financial Fraud Reporting and Prevention

My signature below acknowledges:

My attendance at the Fraud Reporting and Prevention Training on: _____.

Receipt of the New Mexico Judiciary Financial Fraud Policy effective June 3, 2014, and the Supreme Court Order #14-8500 approving the policy, effective June 3, 2014.

Certifies that I understand my responsibilities as a New Mexico Judicial Branch employee of not condoning or engaging in fraudulent activities or behavior, how to report fraud, and the consequences of committing fraud or making false allegations.

That should I have any questions or concerns regarding the training or policy I will contact the AOC Fiscal Services Division at aocfiscal-grp@nmcourts.gov.

_____
Court (Please Print)

_____
Employee Name (Please Print)

_____
Employee Signature Date

Original: Employee Personnel File
Copy: Employee

NEW MEXICO JUDICIAL BRANCH

ACKNOWLEDGEMENT FORM

Drug and Alcohol Testing Policy And Drug-Free and Alcohol-Free Workplace Policy

Questions please call AOC HRD at 505/827-4810 Dev.: 01/24/07; Rvd.02/13/12, 09/25/21

I, _____, acknowledge that I have received, read and
(*Print Name*)
understand the Drug-Free and Alcohol-Free Work Place Policy and the Drug/Alcohol Testing Policy, and I understand that I am responsible for adhering to these policies. I understand that being impaired *to any degree* by alcohol or a controlled substance while on duty for the New Mexico Judicial Branch will subject me to disciplinary action up to and including termination. I realize that the manufacture, distribution, dispensation, use or possession of a controlled substance or alcohol is prohibited on Judicial Branch property or when participating in any Judicial Branch training(s) or other associated activities or in any location where I am on duty performing work for the New Mexico Judicial Branch. Any violation of this policy shall subject me to disciplinary action up to and including termination.

_____ _____

Judicial Entity / Court (Please Print) Employee Signature & Date

Original: Employee Personnel File
Copy: Employee

(1.E.1)

NEW MEXICO JUDICIAL BRANCH
ACKNOWLEDGEMENT FORM

WORKERS' COMPENSATION POLICY

Policy No.2016.NMJB.200

I, _____, an employee of the New Mexico Judicial Branch
(print name)
(NMJB) Administrative Office of the Courts hereby certifies that I have received and read the NMJB AOC Workers' Compensation Policy approved June 27, 2016. I understand it is my responsibility to abide by the Policy.

I accept responsibility for contacting the AOC Human Resources Division, at (505) 470-7205, with any questions or concerns regarding the Workers' Compensation Policy or any policy or NMJB Rule.

_____ _____
Employee Name (Please Print) Court / Division

_____ _____
Employee Signature Date

Original: Employee Personnel File
Copy: Employee

NEW MEXICO JUDICIAL BRANCH

GENERAL PERSONNEL POLICY AND PROCEDURE

Ref: NMJBPR Part 1, Section 1.03; Part 2, Section 15.03

Inquiries: AOC HR (505) 827-4937 or 827-4810
Dev: 09/27/11

Driving with Electronics Policy

I, _____, acknowledge that I have received, read and
(Print Name)
understand the Driving with Electronics Policy , and I understand that I am responsible to adhere to this policy. I understand that while operating any motor vehicle while on-duty, if I must use a cellular communication device, I must use that device in a "hands-free" mode and I will not send text messages, e-mails or access the internet for either personal or professional use. I will comply with all traffic laws, practice defensive driving and strive to operate any motor (either personal or court owned) vehicle safely.

I understand any violation of this policy shall subject me to disciplinary action up to and including termination.

Signature: _____ Date: _____

cc: Employee Personnel File

NEW MEXICO JUDICIAL BRANCH

LANGUAGE ACCESS TRAINING ACKNOWLEDGMENT FORM

My signature below acknowledges:

(1) That I viewed the AOC approved Language Access Training Video.

(2) Receipt of the New Mexico Judicial Branch Language Access Training Policy and Supreme Court Order #11-8500 approving the policy dated October 24, 2011.

(3) My commitment to read and understand the Policy.

(4) That should I have any questions or concerns regarding the training or policy I will contact the AOC Court Services Division, at (505) 827-4822

_____

Name of Court (Please Print)

_____

Employee Name (Please Print) Employee Signature Date

Original: Employee Personnel File
Copy: Employee and Court Services Division
Copy: AOC HR Division

Dev: 10/24/11

Name of Policy: Language Access Training Policy, effective October 24, 2011.
Inquiries: Administrative Office of the Courts, Human Resources Division, 827-4937 or 827-4810
Copy: AOC HR

NEW MEXICO JUDICIAL BRANCH

ACKNOWLEDGEMENT FORM

Loss Prevention and Control & FEMA Training
Active Shooter Video and "How to respond" Manual
Active Shooter Training

My signature below acknowledges my attendance at the New Employee Orientation - Active Shooter Training session presented by the Administrative Office of the Courts, Human Resources Division held on _____.
(Date)

Topics covered included:

- Active Shooter Training

My signature certifies that I understand my responsibilities as a New Mexico Judicial Branch employee to abide by the policies and training requirements, and that I'm responsible for raising with my supervisor and/or Human Resources any questions I may have regarding the training material.

_____
Court (Please Print)

_____
Employee Name (Please Print)

_____
Employee Signature Date

Original: Employee Personnel File
Copy: Employee

(1.H.1)

NEW MEXICO JUDICIAL BRANCH
ACKNOWLEDGEMENT FORM

OSHA TRAINING TUTORIAL ON
PORTABLE FIRE EXTINGUISHERS

https://humanresources.nmcourts.gov/fire-safety.aspx

I, _____, an employee or a Judge of the New Mexico Judicial Branch (NMJB)
(print name)
Administrative Office of the Courts hereby certify I have viewed the OSHA Training Tutorial on Portable Fire Extinguishers located at: https://humanresources.nmcourts.gov/fire-safety.aspx.

I understand that OSHA Regulation 1910-157 (general industry) require this training if staff have access to a fire extinguisher in their building or facility, and prior to their use. I have listened to the OSHA tutorial and have a basic understanding of the general principles of portable extinguisher use, the PASS method (listed below), and the hazards of incipient or early-stage firefighting.

The PASS method consists of four steps:

- Pull the pin
- Aim at base of fire (not at the flames above the base)
- Squeeze the handle
- Sweep the canister side to side

Any fire extinguishers whose pin has been removed, must immediately be reported, and even if it was not used, they may need to be repaired or reset.

I understand that in the event of a fire, it is not my responsibility to try and put out the fire, rather, the use of a fire extinguisher is to help clear the path so that I, my peers, and coworkers may safely and immediately exit the building.

I accept responsibility for contacting the AOC Human Resources Division (HRD), at (505) 827-4810, with any questions or concerns regarding the training, NMJB Rules, or Policies. I understand it is my responsibility to inform management and the AOC HRD of any violation of the NMJB or Personnel Policies.

_____ _____
Judge or Employee Name (Please Print) Judicial Entity / Court / Division

_____ _____
Judge or Employee Signature Date

Original: Judge or Employee Personnel File
Copy: Judge or Employee

Dev: 8/2016

NEW MEXICO JUDICIAL BRANCH
ACKNOWLEDGEMENT FORM

COMPUTER AND INTERNET USE POLICY NO. 2017.NMJB.95

Finalized April 4, 2017

I, _____, an employee of the New Mexico Judicial Branch (NMJB) hereby
(print name)
certify that I have received the revised Computer and Internet Use Policy No.2017.NMJB.95. I understand it is my responsibility to read and abide by the revised Computer and Internet Use Policy, all NMJB Personnel Rules, Policies, as well as any internal policies of my Judicial Entity. These materials are general in nature and do not address all the possible applications of, or exceptions to the Policies and Procedures.

I received a copy of the Computer & Internet Use Policy & Supreme Court Order on: _____.

EMPLOYEES: I realize that violation of this policy can subject me to disciplinary action, up to and including dismissal.

JUDGES: I understand that violation of this policy can subject me to the superintending control of the New Mexico Supreme Court and the disciplinary jurisdiction of the New Mexico Judicial Standards Commission and the New Mexico Supreme Court.

I understand it is my responsibility to inform management and JID of any violation of the NMJB Computer and Internet Use Policy, including the receipt of any prohibited and inappropriate content sent to me at my nmcourts.gov email address.

I understand it is my responsibility to inform JID, my Judicial Entity's IT security office and Human Resources should I receive an email that might be in violation of Section 5.F.8 of the computer and Internet Use Policy; and that Human Resources must be notified prior to an inappropriate item being deleted.

I understand it is my responsibility to inform senders to not send inappropriate items to my work email, and/or unsubscribe from any site that may be deemed inappropriate.

I accept responsibility for contacting the AOC Human Resources Division, at (505) 470-7205, with any questions or concerns regarding the training, NMJB Rules, or Policies.

_____ _____
Employee or Judge Name (Please Print) Judicial Entity / Court / Division

_____ _____
Employee Signature Date

Please return to your Judicial Entity's HR Professional

Original: Employee Personnel File
Copy: Employee

NEW MEXICO JUDICIAL BRANCH

ACKNOWLEDGEMENT FORM
Harassment, Including Sexual Harassment, Discrimination & Retaliation Prevention Policy

Reference NMJBPR Part 1, Section 1.05 & NMJBPR Part 2, Section 15.05
Questions please call AOC HRD at aochrd-grp@nmcourts.gov Rvd. 9/16/14, 11/26/18; 9/30/21

I, _____, an employee of the New Mexico Judicial Branch hereby certify
(print name)
receipt of the NMJB Harassment, Including Sexual Harassment, Discrimination and Retaliation Policy revised effective September 30, 2021, and the Supreme Court Order #06-8500 approving the policy, effective August 18, 2006. I understand it is my responsibility to read and abide by the Policy and Supreme Court Order as well as any internal policies of my Judicial Entity.

I realize that harassment, sexual harassment, discrimination and retaliation are prohibited by the New Mexico Judicial Branch and the Supreme Court of New Mexico, and all employees have the right to work in an environment free from unwelcome behavior or comments of a harassing, discriminatory or sexual nature either by coworkers, supervisors, or non-employees who conduct business with the Judicial Branch.

Similarly, those the Judicial Branch serves have a right to receive services free from any harassing, discriminatory or sexual comments or behavior. Harassment based upon an individual's sex, race, color, ethnicity, national origin, age, ancestry, religion, sexual orientation, gender identity, disability or any other legally protected characteristics will not be tolerated.

No person will be adversely affected in employment or retaliated against as a result of bringing complaints of unlawful harassment. Behaviors such as intimidating, coercing, threatening, discriminating against or taking reprisal against an employee for complaining about harassment or discrimination, or for assisting with an investigation of a complaint is prohibited.

I realize that violation of this policy can subject me to disciplinary action, up to and including dismissal. I also realize it is my responsibility to inform management and the AOC of all instances of sexual harassment and discrimination in order for prompt remedial action to be taken. I agree that I will take a proactive stance against instances of sexual harassment and discrimination.

_____ _____
Judicial Entity / Court (Please Print) Employee Signature & Date

Original: Employee Personnel File
Copy: Employee

(1.K.1)

NEW MEXICO JUDICIAL BRANCH
ACKNOWLEDGEMENT FORM

Administrative Office of the Courts
Vehicle & Mileage Reimbursement Policy

Policy No.2024.AOC.208

I, _____, an employee of the Administrative Office of the Courts
(print name)
(AOC) hereby certifies that I have received and read the NMJB AOC Vehicle & Mileage Reimbursement Policy approved April 11, 2024. I understand it is my responsibility to abide by the Policy.

I accept responsibility for contacting the Administrative Office of the Court's Fiscal Services Division at aocfiscal-grp@nmcourts.gov with any questions or concerns regarding the Vehicle & Mileage Reimbursement Policy.

_____ _____
Employee Name (Please Print) Division

_____ _____
Employee Signature Date

Original: Employee Personnel File
Copy: Employee

NEW MEXICO JUDICIAL BRANCH
ADMINISTRATIVE OFFICE OF THE COURTS
ACKNOWLEDGEMENT FORM

FAIR LABOR STANDARDS ACT (FLSA) & OVERTIME COMPENSATION

7/15/2016

IMPORTANT INFORMATION ~ READ CAREFULLY

Please read the following statements and sign below to indicate your receipt and acknowledgement of the Administrative Office of the Courts communication regarding the Fair Labor Standards Act and your role and responsibility both as an employee responsible for accurately entering all actual hours worked into the SHARE time reporting system, and as a supervisor or manager responsible for ensuring your employees are paid accurately for hours worked.

****

The Federal Fair Labor Standards Act (FLSA) identifies compensable hours, defines overtime and overtime compensation, which apply to the NMJB and the Administrative Office of the Courts.

Overtime or any extra hours worked must be approved by your Division Director and the AOC Director prior to being worked.

Non-Exempt Employees: Non-exempt employees are covered by the minimum wage and overtime provisions of the FLSA and are **entitled** to overtime compensation at one and one-half times their regular rate of pay for hours worked beyond 40 in a work week.

Compensatory Time Off in Lieu of Cash: Compensation occurs in the form of compensatory time (comp time) unless Division Director and AOC Director approval is received for the compensatory time to be paid out.

Time Worked for Overtime Purposes includes regular hours, training and workshop hours, travel time required by management, and voting time. (Other types of leave may offset the one and one-half to straight time). See the NMJBPR Glossary of Terms for more information. **Breaks and Meal Period:** Non-exempt employees approved to work a flexible schedule are required to schedule at least a ½ hour each day for lunch.

Exempt Employees: Exempt employees are not covered by the FLSA's regulations pertaining to overtime and ***may, with prior approval*** receive compensatory time at straight time for hours worked beyond 80 in a pay period. Compensation is typically compensatory time (see the NMJBPR).

Breaks: It is important to remember that breaks are not mandatory. Employees may be permitted one 15 minute mid-morning break and one 15 minute mid-afternoon break. Breaks cannot be accumulated, cannot cover for later arrival to work, extended lunch hours, or early departure from work. The time spent on authorized breaks must be counted as hours worked.

Meal Periods: Even though the FLSA does not require employers to provide meal periods, it does stipulate that if one does exist, at least 30 minutes or more constitute a bona fide meal period. Meal periods are not counted as worktime. Normally, employees remove themselves from the work location

and are therefore not performing any duties. However, when an employee remains at the work location and while eating performs any job-related duties, other than incidental ones (such as answering a question), the time must be counted as hours worked. Supervisors may adjust an employee's work schedule to prevent an overtime situation when an employee works during a meal period.

Suffered or Permitted Work Hours: Work not requested and approved in advance, but suffered or permitted is still considered hours worked. This may occur when an employee begins to work prior to the beginning of the day, during lunch hours, or continues to work at the end of the day without approval. **When the supervisor has knowledge of or has reason to believe that the employee is working additional hours that have not been requested and approved, the hours must still be counted as hours worked.**

I,_____, hereby certify that I have read and reviewed the above
(print name)
communication regarding the Fair Labor Standards Act and understand my responsibility as an employee to ensure I enter actual hours worked into the SHARE time reporting system. I understand that all extra hours worked require prior authorization. I understand that non-exempt employees accrue compensatory time in lieu of payment of overtime in accordance with the provisions of the Fair Labor Standards Act. If you are an FLSA non-exempt employee, your signature indicates your understanding that working unapproved extra hours resulting in overtime may result in disciplinary action.

I understand as a supervisor or manager (should I be one or become one), that I am responsible for ensuring that my employees enter their time into the SHARE time reporting system accurately. I understand that all hours worked by my non-exempt employees must be entered and compensated even if they were not approved in advance. [The non-approval is a separate issue that I may bring to the AOC HR Division to address.]

I understand it is my responsibility to inform my Division Director and the AOC HR Division Director of any violations of the Fair Labor Standards Act and this Directive. **I realize that violation of the Fair Labor Standards Act and this directive can subject me to disciplinary action, up to and including dismissal.**

_____ _____
Employee Name (Please Print) Division/Court

_____ _____
Employee Signature Date

CC: Employee Personnel File

Administrative Office of the Courts

Supreme Court of New Mexico

{Administrative Authority}
{HR}

{Street Address}
{City, State, and Zip Code}
{Phone Number}
{Fax Number}

DATE:

TO:

FROM: {HR or Administrative Authority}

CC: Employee Personnel File, AOC HRD Position File

RE: Fair Labor Standards Act Determination

The Fair Labor Standards Act (FLSA) is a federal statute that was enacted by the United States Congress to ensure that fair and minimal standards are met in the workplace. The Act mandated, among other things, that employees in certain jobs be compensated at one and one-half times their hourly rate of pay for each hour worked in excess of 40 hours in a work week. According to the FLSA, four categories of work are "exempt" and not entitled to overtime pay. To ensure that all employees of the New Mexico Judicial Branch who are entitled to overtime compensation receive it, each job classification and position has been reviewed and a determination has been made identifying the positions that should be considered "exempt" and "non-exempt" by these federal protections.

Exempt Employees – Exempt employees are not covered by the FLSA's regulations pertaining to overtime and may, with prior approval, receive compensatory time at straight time for hours worked beyond 80 hours in a pay period.

At-Will Exempt Employees – At-will exempt employees are required to record all actual hours worked each pay period. Any extra hours worked must be entered on your time sheet as extra hours worked for tracking purposes only. At-will employees are only allowed to flex extra hours worked within the same pay period as they worked, and are not permitted to accrue compensatory time to be utilized in the future.

Non-Exempt Employees – Non-exempt employees are covered by the FLSA's regulations and are entitled to overtime compensation at one and one-half times their regular rate of pay for hours worked beyond 40 in a work week. There are New Mexico Judicial Branch Personnel Rules, policies and practices that are important to be aware of with regards to your new FLSA determination, including but not limited to the following:

- **Compensation for overtime will be in the form of compensatory time** (comp time) unless your Administrative Authority or designee approve for the compensatory time to be paid out.
- Extra hours worked require prior authorization and approval. Time worked for the purposes of overtime including regular hours, training and workshop hours, travel time required by management, and voting time. Other types of leave may offset the time and one-half to straight time.
- **Previously approved flexible work schedules or alternative work schedules must be reapproved** to ensure they do not result in any unplanned and unbudgeted overtime.
- **Previously approved extra hours worked must be reapproved due to the budgetary impact.**

- Non-exempt employees approved to work a flexible schedule are typically required to schedule at least a 30 minute lunch break each day.
- Meal periods are not counted as work time. Normally, employees remove themselves from the work location and are therefore not performing any duties. However, when an employee remains at the work location and while eating performs any job related duties, other than incidental ones (such as answering a question); the time must be counted as hours worked.
- Supervisors may adjust an employee's work schedule to prevent an overtime situation.
- Work not requested and approved in advance, but suffered or permitted is still considered hours worked. This may occur when an employee begins to work prior to the beginning of the day, during lunch hours, or continues to work at the end of the day without approval.
- It is an employee's responsibility to ensure all actual hours worked are reported into the time reporting system accurately and all extra hours have been approved in advance of working them.

If you have any questions on the Rules or policies please talk to your manager or HR Professional.

Job Classification Determination

[to be completed by HR]

Due to the FLSA compensation test and your hourly rate of $XX.XX your position as a full-time <<XX>> (position #XXXXXXXX) is determined to be X non-exempt ☐ exempt from the FLSA.

PLEASE SIGN ONE OF THE RESPONSES BELOW

I **agree** with the NMJB's determination of the FLSA category and exemption status for my position. If I am an FLSA non-exempt employee, I **agree** to the provisions of time off as compensation for overtime work, and consent to the use of compensatory time in accordance with the NMJB Rules and Policies. I hereby agree to accept compensatory time-off in lieu of cash payment for overtime worked. I understand that I may request cash payment for overtime worked; however due to budget constrains it may or may not be available.

Employee Signature: _____ Date: _____

I **disagree** with the NMJB's determination of the FLSA category and exemption status for my position. I believe my position should be categorized as ☐ **non-exempt** ☐ **exempt from the FLSA. Attached justifications is required.**

Employee Signature: _____ Date: _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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. A noncitizen (other than **Item Numbers 2.** and **3.** above) 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, 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 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.
		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				

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 07/31/2026

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 07/31/2026

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.

PERSONAL DATA UPDATE FORM

(2.B)

Please return to Human Resources

NEW FORM: _____ CHANGE: _____

Effective Date of Change: _____ Entered By: _____ Date: ____/____/____

Employee Information

Name: _____ EMPL ID #: _____ Date of Birth: ____/____/_____

Social Security #: _____ E-mail Address (work/personal):_____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Are you currently or have you ever worked for the State of New Mexico? _____
*If yes, please provide approx. dates. _____

Voluntary Information

Gender:
☐ Male ☐ Female ☐ **Retired State Employee**

Marital Status:
☐ Single ☐ Married - Date of Marriage_____ ☐ Divorced - Date of Divorce_____
☐ Common Law ☐ Head of Household ☐ Separated
☐ Widowed

Ethnicity (Check one):
☐ Asian ☐ Black/African American ☐ Caucasian/White
☐ Hispanic/Latino ☐ Native American/American Indian ☐ Native Hawaiian or Other Pacific Islander
☐ Decline to Identify/Not Specified ☐ Other _____

Military Status (Check if appropriate):
☐ Active Reserve ☐ Inactive Reserve ☐ No Military Service
☐ Retired Military ☐ Vietnam Era Veteran ☐ Other Protected Veteran
☐ Special Disabled Vietnam Veteran ☐ Special Disabled Veteran ☐ Other _____

Highest Education Level: (Check one below)
☐ Less than a High School Graduate ☐ High School Graduate/GED or Equivalent ☐ Some College
☐ Technical School/Trade Certificate ☐ 2 Year College/Associate's Degree ☐ Bachelor's Level Degree
☐ Some Graduate School ☐ Master's Level Degree ☐ Doctorate (Academic)
☐ Doctorate (Professional) ☐ Post Doctorate ☐ Other _____

Total Years of Education _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: (_____) Work Phone: (_____) Cell/Other (___) _____.

_____ _____

Employee Signature: **Date:**

Saved in: K:\FORMS\PERSONAL DATA\2015 PERSONAL DATA FORM
(Form Revised: 02/2/2015)

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

2024

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.)

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 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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

State of New Mexico – Department of Finance and Administration

DIRECT DEPOSIT AUTHORIZATION AND AGREEMENT OR DECLINATION

EMPLOYEE INFORMATION

EMPLOYEE NAME: PEOPLESOFT ID#:

DISBURSEMENT CHOICE – CHECK AND SIGN ONLY ONE OPTION

☐ **DIRECT DEPOSIT ENROLLMENT OR CHANGE AUTHORIZATION AND AGREEMENT**

Type of action (select one): ☐ New Enrollment ☐ Account Change

Financial institution and account information:

Financial Institution Name and Address	Type *Checking = C* *Savings = S*	Routing Number *(from your financial institution)*	Account Number *(employees may have only one direct deposit account)*

Proof of ownership: For the single account that you own, in whole or in part, and to which you want 100% of your net salary and wages directly deposited, please attach one of the following forms of documentation. For a checking or savings account, you may attach the first page of the most recent bank statement for the account showing your name on the account and the account number, with all financial information (e.g., balances and transactions) redacted. Alternatively, for a checking account, you may attach a voided, preprinted check listing you as an account owner.

Authorization and agreement:

I authorize the State of New Mexico (State) to directly deposit my net salary and wages to the account designated above and my financial institution to accept such deposits and credit them to this account. I understand and agree that:

- 100% of my net salary and wages will be electronically transferred to my financial institution and credited to the account designated above on paydays designated by the State;
- this direct deposit authorization and agreement supersedes and replaces any prior direct deposit authorizations and agreements, which I hereby revoke, and will continue in effect until I designate another account or I or the State cancel my enrollment in direct deposit;
- if the State is notified that the account designated above has been closed, I will receive payroll warrants until I designate a new direct deposit account;
- the State may, without liability to me, cancel my enrollment in direct deposit at any time, either temporarily for one or more pay periods or permanently, in which event I shall receive payroll warrants for the effected pay periods;
- in the event that my financial institution does not accept the direct deposit of my net salary and wages for any reason, the State has no obligation to process a supplemental salary and wage payment until my financial institution returns the non-accepted payment to the State; and
- I can cancel my enrollment in direct deposit or change my direct deposit account at any time. I understand and agree that it may take some time for the cancellation or change to take effect, during which time my net salary and wages will continue to be directly deposited in the account designated above.

In the event that more money is deposited into my account than is due me, I authorize the State to deduct from the account designated above all amounts deposited to the account in error and authorize my financial institution to allow such deductions and return the erroneously paid amounts to the State.

Employee Signature: _____ Date:

☐ **PAYROLL WARRANT** Notwithstanding that direct deposit is quicker (i.e., enrolling in direct deposit would mean my net pay would be in my account on payday), safer (i.e., payroll warrants can be lost or stolen), and convenient (i.e., by enrolling in direct deposit, I would not have to cash or deposit a payroll warrant or worry about being out of the office on a payday), I decline to participate in the State of New Mexico direct deposit program and hereby revoke any prior direct deposit authorizations and agreements. I understand that payroll warrants will be delivered to my employer on paydays and that I must retrieve the warrant from my employer and cash or deposit the warrant to have access to my pay.

Employee Signature: _____ Date:

(3.A)

PERA
Public Employees
Retirement Association
of New Mexico

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PERA Membership

33 Plaza La Prensa
Santa Fe, NM 87507
(505) 476-9300 phone
(505) 954-0370 fax
www.nmpera.org

Instructions: Please print or type in dark ink. This form must be completed in its entirety and submitted to PERA via regular mail, fax, or e-mail to noreply.records@state.nm.us for processing.

Section 1 Information About You

☐ CŜY I·ƒŜ ☐ a I·ƒŜ

Social Security Number or PERA ID | Name (First, Middle Initial, Last)

Date of Birth (mm/dd/yyyy) | City of Birth | State of Birth

( ) Phone Number | E-mail Address

Mailing Address | City | State | Zip Code

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed

Have you ever been a PERA Member? ☐ Yes ☐ No — Are you currently receiving a PERA pension? ☐ Yes* ☐ No

Have you ever been an ERB Member? ☐ Yes ☐ No — Are you currently receiving an ERB pension? ☐ Yes* ☐ No

*If yes, please contact PERA before beginning employment. Refer to Re-Employed Retiree Form.

*If yes, complete an Exclusion from PERA membership form.

Spouse's Name, SSN, and Date of Birth (mm/dd/yyyy)

Children's Name(s), SSN(s), and Date of Birth(s) (mm/dd/yyyy)

Section 2 Your Certification

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

Signature of Employee | Date (mm/dd/yyyy)

Remember to send corrections to PERA if any of the above information changes. Annual member statements and PERA election ballots are mailed to the most recent address PERA has on file for you. It is your responsibility to keep your information current.

Section 3 Your Current Employment Information (To be completed by Employer)

tƒŜI·ăŜ retain a copy of the completed application for your files and provide a copy to ǘKŜ ŜYƚƒƨèŜŜ. {ǳōYʎǘ ǘKŜ ŏϩYƚƒŜǘŜŘ I·ƚƚƒǺI·ǘϩɣ ǿʎǘK PERA's . ŜɣŜƬʎǾʎI·ƝèƝ 5ŜăʎƎYI·ǘʎϩɣƭϩƝY ǘϩ t9w! ʎYYŜŘʎI·ǘŜè I·ŦǘŜƝ ŏϩYƚƒŜǘʎϩɣ ɣϩƝŜƚƒèϩƝŜϩƝŘă ẊăǘI·ǘŜϕɣYϕǳă ϩƝ ǳƚƒϩI·Ř ǘϩ t9w! ǫă C¢t ăʎǘŜϕ

Name of Employer | PERA Employer / ϩŘŜ | PERA Plan

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Section 4 Your Employer Certification (To be completed by Employer)

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( ) Authorized Employer* Printed Name | Title | Email Address | Phone

Signature of Authorized Employer* | Date (mm/dd/yyyy)

*HR Manager, Payroll Manager or Finance Manager

December 2021

PERA
Public Employees Retirement Association of New Mexico

Active (Non-Retired) Beneficiary Designation

33 Plaza La Prensa
Santa Fe, NM 87507
(505) 476-9300 phone
(505) 954-0370 fax
www.nmpera.org

Instructions: Please print or type in dark ink. This form must be completed in its entirety and returned to PERA via regular mail, fax, or e-mail to noreply.records@pera.nm.gov for processing. To be completed by an Active (Non-Retired) PERA Member prior to retirement.

Section 1 Information About You

Social Security Number or PERA ID | Name (First, Middle Initial, Last)

Date of Birth | ( ) Phone Number | E-mail Address

Mailing Address | City | State | Zip Code

Marital Status: ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced*

*Note: PERA requires the review of **ALL** court-endorsed divorce documentation. If your divorce was prior to PERA membership, please submit a copy of the first page of your Final Divorce Decree ONLY. If you remarried PRIOR TO PERA membership and are still married to the same person no divorce decrees are required.

Section 2 Information About Your Spousal Consent

☐ Check here if you are married and designating someone other than your spouse. If this box is checked, you must submit a separate completed Beneficiary Spousal Consent form for this designation to be effective.

Section 3 Information About Your Survivor Beneficiary

*You may only choose one person. You may NOT split between more than one person.

I designate the following person to be my survivor beneficiary to receive a monthly pension payable for life in the event of my death prior to retirement. If I have less than the minimum number of years to meet retirement eligibility when I die, this monthly pension will be payable only if my death is duty related as provided by law.

Name (First, Middle Initial, Last) | Relationship | SSN/Fed Tax ID

Date of Birth | ( ) Phone Number | ☐ Same as above Mailing Address

Section 4 Information About Your Refund Beneficiary

*You may only choose one person or organization. You may NOT split between more than one person or organization.

If no survivor pension is payable, I designate the following person or organization to be my refund beneficiary to receive a refund of my accumulated member contributions. If I do not designate a refund beneficiary, I understand the refund amount will be paid to my estate.

PERSON

Name (First, Middle Initial, Last) | Relationship | SSN/Fed Tax ID

Date of Birth | ( ) Phone Number | ☐ Same as above Mailing Address

***OR* ORGANIZATION**

Organization Name | ( ) Phone Number | Mailing Address | Tax ID #

Section 5 Your Authorization

I hereby declare that as an Active (Non-Retired) Member that all the information provided is true and complete to the best of my knowledge.

Signature of Member | Date

PERA
Public Employees
Retirement Association
of New Mexico

INVESTED IN TOMORROW.

PERA Beneficiary Designation Form Instructions & Guidance

It is important for all of our valued members to understand and know how beneficiary designation works, and what benefits each provides. These instructions and guidance should be clearly shared with your beneficiary designation so they are informed of what processes are needed to be completed in the event of a death. We encourage all members to update beneficiary designations as life events change to ensure your beneficiary designation is current and accurate. These beneficiaries are only valid until the time of retirement where beneficiaries are named again on the Application for Pension Form. Other life changes such as marriage and divorce can also automatically revoke designations in accordance with NMSA 1978 Section 10-11-124 D.

The instructions and guidance below will provide you with a better understanding of each section on the Beneficiary Designation Form.

Check the appropriate box at the top if the form is a new designation or a change in existing information. If you are a retiree, you may not change your beneficiary with this form. Please contact PERA's Member Services Division at 505- 476-9300 for further guidance.

Member Information Section

Instructions

- The member or employer completes this section. All fields must be complete.
- If you are married, you may not designate a beneficiary other than your spouse without attaching a notarized *Beneficiary Spousal Consent Form*.
- If you are requesting a beneficiary designation change due to a marital status change you will be required to provide the following documentation before your designation can be changed.
  - If your marital status is changing to Married:
    - A copy of your marriage certificate certifying that you have been legally married.
    - If you or your spouse changed your name after the marriage please provide legal name change documents, a copy of a NM Driver's License or passport showing the new legal name and a Social Security card showing the name change.
    - Name changes must also be requested by the member or the beneficiary. If you are the member and your spouse changed their name they will have to request the change in writing or on a *Change in PERA Records Form* with their signature.
  - If your marital status is changing to or from Divorced:
    - A court-endorsed copy of your Final Divorce Decree and Marital Settlement agreement (if applicable). If you were divorced prior to becoming a member only the first page of the court-endorsed Final Decree is required.

- The divorce documentation can reflect a name change however, the following is also required: a copy of a NM Driver's License or U.S. Passport showing the new legal name and a Social Security card showing the name change.

- If your marital status is changing to Widowed:
  - A copy of your spouse's death certificate.

Survivor Beneficiary Information Section

Guidance
When a member names a Survivor Beneficiary they are naming a person who will be paid out in the event of death after a member is vested. The person that is named the survivor beneficiary has only one year from the member's date of death to provide PERA with the death notification, and/or other required documents. Such documents would include, but are not limited to a Death Certificate, proof of identity, Social Security card, all court-endorsed Final Divorce Decrees and Marital Settlement Agreements, Estate Documents and Last will and Testament. If the member names a different person as the refund beneficiary and the survivor beneficiary designation does not complete the application for annuity process they would not be entitled to any benefits or funds that may remain in the account.

Instructions

- Enter the name of the **one** person to be designated as the survivor beneficiary. You may **NOT** designate more than one person or split beneficiaries. PERA must have the name and birth date of the designated beneficiary. PERA strongly encourages including the relationship of the designated beneficiary. It is required to include a Social Security Number or Federal Tax ID and birthdate of the designated beneficiary.
- You must provide a valid Social Security Number and a valid Date of Birth for your beneficiary designation or we cannot enter it into our system.
- If you choose a beneficiary who is not a U.S. Citizen we will keep your designation on file, however no funds can be paid out in the event of death without a Federal Tax ID. This must be supplied at the time your beneficiary claims benefits.

Refund Beneficiary Information Section

Guidance
When a member names a Refund Beneficiary they are naming a person or organization who will be paid out in the event of death before a member is vested (different time periods for Tier 1 members and Tier 2 members) under PERA's requirements. It is important to note that this designation is entitled to funds when survivor benefits are not claimed within one year of a member's date of death. If the deadline is missed, and even though a Survivor Beneficiary is named, the designated beneficiary is not entitled to any funds remaining in the member's account. We urge all members to designate a Refund Beneficiary. If there is not a refund beneficiary designation the funds can only be paid to an estate.

Instructions

- Enter the name of the **one** person to be designated as the refund beneficiary. You may **NOT** designate more than one person or split beneficiaries. PERA must have the name and birth date of the designated beneficiary. PERA strongly encourages including the

relationship of the designated beneficiary. It is required to include a Social Security Number or Federal Tax ID and Date of Birth for the designated beneficiary.

- You must provide a Social Security Number and a valid Date of Birth for your beneficiary designation or we cannot enter it into our system.
- If you choose a beneficiary who is not a U.S. Citizen we will keep your designation on file, however no funds can be paid out in the event of death without a Federal Tax ID. This must be supplied at the time your beneficiary claims benefits.
- **Or** if an organization is designated as a Refund Beneficiary, complete the name, address and organization tax ID number.

Spousal Consent Section

Instructions

- If the member is married and naming someone other than his or her spouse the member must complete the *Beneficiary Spousal Consent Form*. The spouse's signature must be notarized and both forms must be submitted to PERA at the same time in order for the *Beneficiary Designation Form* to be valid.

Member Authorization Section

Instructions

- The member must sign and date the form.

PERA will accept faxed and scanned copies of this form as long as the member does not need the *Beneficiary Spousal Consent Form*. If a married member chooses someone other than his or her legal spouse, PERA must receive the original of the *Beneficiary Designation Form* and the *Beneficiary Spousal Consent Form*.

PERA
Public Employees
Retirement Association
of New Mexico

Beneficiary Spousal Consent

33 Plaza La Prensa
Santa Fe, NM 87507
(505) 476-9300 phone
(505) 954-0370 fax
www.nmpera.org

Instructions: Please print or type in dark ink. This form must be completed in its entirety and returned to PERA via regular mail, fax, or e-mail to noreply.records@pera.nm.gov for processing.

Section 1 Information About You

______________________________ | ______________________________

Social Security Number or PERA ID | Name (First, Middle Initial, Last)

Section 2 Information From Your Spouse

*Must be signed in presence of a notary

IΣ ψψψψψψψψψψψψψψψψψψψψψψ______________, am married to PERA member ______________________________________. I hereby
Spouse's Name (please print) | Member's Name (please print)

consent to my spouse's decision to name ____________________________________ as his/her survivor beneficiary and
Survivor Beneficiary's Name (please print)

____________________________________ as his/her refund beneficiary to receive retirement benefits in the event my spouse dies
Refund Beneficiary's Name (please print)

prior to retirement.

____ | ______________

{λΞyƖ·űdzǋŜ ƻŦ Member's Spouse | Date

PERA Rule 2.80.700.10B(3) NMAC requires that the retiring member provides PERA with court endorsed copies of all divorce orders and marital settlement agreements entered after the first PERA membership application is filed, if the member has been previously married.

Section 3 Information About Your Notary

State of ____________________)
) SS:
County of __________________)

Signed and sworn to (or affirmed) before me by ____________________________ on this the _______ day of
Spouse's Name (please print)

____________________, __________.

My Commission Expires_______________

Notary Public Telephone Number _______-______-_______

Signature of Notary ____

*Notary stamp must be visible

State of New Mexico

Benefits Eligibility Acknowledgement

Congratulations on your recent employment.

This document contains important information regarding health benefit options that are offered to you as a benefit-eligible employee through the State of New Mexico (SoNM). The document must be read (to its entirety), signed, dated and returned within the first week of employment to the dedicated Human Resource Office/State Personnel Office representing your Agency.

Should you have any questions regarding benefit options, eligibility, form requirements or deadlines, please contact the SoNM's Third Party Administrator (TPA); Erisa Administrative Services, Inc., at 1-855-618-1800.

*Para asistencia en español con este formulario, por favor llame a Erisa al 1-855-618-1800

CARRIER	GROUP NUMBER	CUSTOMER SERVICE LINE	WEBSITE
EMPLOYEE ASSISTANCE PROGRAM (EAP) WELL BEING SOLUTIONS	N/A	1-833-515-0771	WELL BEING SOLUTIONS-EAP
PRESBYTERIAN - HMO	A0000034	1-888-275-7737	PRESBYTERIAN
BCBS OF NEW MEXICO - HMO	N66004	1-877-994-2583	BLUE CROSS BLUE SHIELD
BCBS OF NEW MEXICO - PPO	266002		
CIGNA-OAPIN	3343553	1-800-244-6224	CIGNA-HMO
CIGNA-OAP	3343553	1-800-244-6224	CIGNA-PPO
CVS CAREMARK	RX22AR	1-877-744-5313	CVS CAREMARK
DELTA DENTAL	8523	1-877-395-9420	DELTA DENTAL
EYEMED	(State) 1028738 (LPB) 1028739	1-855-219-3138	EYEMED
SONM SHORT/LONG TERM DISABILITY EASI	N/A	1-855-618-1800	DISABILITY
THE HARTFORD	681601	1-855-618-1800 Life Claims: 1-888-563-1124	THE HARTFORD
FLEXIBLE SPENDING ACCOUNT (FSA) Erisa, Inc.	N/A	1-855-618-1800	FLEXIBLE SPENDING ACCOUNT-FSA
COBRA	N/A	1-855-618-1800	COBRA
VOLUNTARY BENEFITS			
AFLAC	M4X48	1-505-510-0156	AFLAC
GLOBE	N/A	1-303-717-8122	GLOBE
THE HARTFORD	681902	1-855-396-7655	THE HARTFORD
METLIFE	228995	1-855-862-3912	METLIFE
WELLNESS PROGRAMS			
Health and Wellness		WELLNESS PROGRAMS	

Information regarding the benefits offered through the SoNM, as well as the on-line enrollment form, carrier contact information, etc., can be found at www.mybenefitsnm.com.

EMPOYEE ELIGIBILITY

To be eligible for coverage an employee must be hired as Classified, Exempt, Probationary, Temporary, Term or Hourly and scheduled to work 20 hours or more per week**.**

DEPENDENT ELIGIBILITY

To be eligible for coverage a dependent must be one of the following:

- A lawful spouse or a Domestic Partner (DP);
- A biological child, adopted child, step-child (if married to the biological parent), or child of the DP
  - Dependent children may be covered up to the end of the month of their 26th birthday

DUE DATES

Enrollment/Waiver Form - New hires must complete the on-line Benefits Enrollment/Waiver Form **within 31** calendar days of hire date. **Enrollment must be completed on line.** The on-line form must be completed even if employee intends to waive coverage to all offered benefits. The Benefits Enrollment/Waiver Form can be found at www.mybenefitsnm.com. If enrollment is not received 31 calendar days from the date of hire, enrollment into the benefits program will not be allowed until the next Annual Open enrollment or a qualifying event (see Qualifying Event section on next page). No exceptions will be made.

Proof of Dependency Documents – must also be submitted **with-in 31 calendar days** of date of hire

DEPENDENT ENROLLMENT

It is strongly recommended to fax the proof of dependency documentation to the TPA (505-244-6009) the same day as the on-line enrollment/waiver form is submitted in order to avoid any delays in coverage. If the required documentation is not received **within 31 days of the date of hire**, the dependent will not be added to coverage. **Note:** The next opportunity for enrollment would then be with either a Qualifying Event (QE), or at the next annual Open Enrollment.

Proof of dependency documents consist of: marriage certificate, domestic partner affidavit, birth certificate******, court issued placement or adoption papers, or the domestic partner affidavit listing the eligible dependent.

******If a birth certification is not available, please contact the TPA for other possible options.

HEALTH BENEFIT PREMIUM RATES

The Benefits Contribution Schedule can be found at www.mybenefitsnm.com under the **Employee Resources link at the top of the homepage, Benefits Information, Premium Rate Information.**

Note: Annualized salary is based on a 40-hour workweek, which is used to determine insurance premiums for those hired on an hourly-basis, even if they are scheduled to work less than 40 hours per week.

QUALIFYING EVENTS – Change of Status

If a qualifying event (shown below), is experienced and employee wishes to make changes to elected benefits, these changes must be made using the on-line Benefits Enrollment/Waiver Form. The form, as well as the documentation supporting the qualifying event must be submitted within **31 calendar days** of the event.

- Change in marital status such as marriage, domestic partnership (DP), divorce/legal separation or termination of DP.
  Note: Failure to remove the ex-spouse/DP and DP child/ren or step child/ren within **31 days** of becoming **ineligible** may forfeit employee's ability to participate in the State's Benefits Program.
- Birth of a child, court approved adoption, placement for adoption, or legal guardianship.
- Death of a dependent.
- Change in job status of SoNM employee: employment (changing from part-time to full-time or vice versa), reduction in hours due to FML, LWOP, and/or Disability, or Military Leave.
- Change in job status of spouse/domestic partner resulting in loss of group coverage due to termination or gain of other coverage due to new employment.
- Any other circumstance where the employee had outside coverage, then loses this coverage due to circumstances beyond their control, eligibility to participate in SoNM's Benefit Program must be evaluated by the Risk Management Division.

NOTE: Loss of a provider or provider group from carrier coverage is not a qualifying event.

ACKNOWLEDGEMENTS

- ☐ I understand it is my responsibility to elect and submit coverage for myself and my eligible dependents within 31 days from the date of hire and also understand that if I do not do so within 31 days, the next available opportunity will be either 31 days from a qualifying event, or the next annual Open Enrollment event.
- ☐ I am aware that benefits premiums are deducted on a bi-weekly basis (each paycheck).
- ☐ I am aware that benefits terminate on the last pay period in which premiums were deducted or paid via self-pay.
- ☐ I understand it is my responsibility to remove any dependents who do not meet the eligibility requirements, within the 31 days of the dis-qualifying event. Failure to do so may result in my losing the ability to participate in any health benefits offered by the SoNM, as well as full reimbursement of all claims paid out on behalf of the dis-qualified dependent.
- ☐ I understand it is my responsibility to review my bi-weekly pay advice to ensure deductions are accurate. If deductions are not accurate I must contact the TPA (1-855-618-1800) immediately.
- ☐ I understand when out on Family Medical Leave, Leave Without Pay, or Leave when on Disability I am responsible for payment of premiums for any benefits elected. Failure to submit payment by the due date will result in loss of coverage.
- ☐ I understand that I cannot claim both Workers Compensation and Disability during the same time frame.

By signing this form employee acknowledges they have read this document in its entirety and understand their responsibilities required to participate in the State of New Mexico's Benefits Program.

Directions to Electronically Sign: Click on Tools on the top left corner, in right window pane click Fill & Sign, Click Sign icon  ***on top window pane, select signature, and drag and place in desired area.***

Employee Name/Employee ID# (Print) ***Please keep a copy of this form for your records***	**Employee Signature and Date (Required)**
HR Representative Signature	**Date (Required)**

THE HARTFORD

BENEFICIARY DESIGNATION

Effective: July 1, 2019

Policy # 681601

As a new member of The Hartford please designate your primary beneficiary as well as a contingent beneficiary.

What is a contingent beneficiary? A contingent beneficiary is a beneficiary utilized in the event the primary designated beneficiary is deceased, unable to be located, or refuses inheritance at the time benefits are to be paid. The named contingent beneficiary will receive and is entitled to your benefit.

Directions:

- Submit original Beneficiary Designation form to human resource administrator.
- Keep a copy for your personal records.
- Fax a copy to Erisa 505-244-6009

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

SAMPLE

State of New Mexico Employee Enrollment/Change Form

Enrollment/Change forms must be completed electronically and to its entirety. No hand-written forms will be accepted or processed.

Section A: EMPLOYEE INFORMATION

SSN / ITIN	2. Employee (Last, First, M.I.)	3. Date of Birth	4. Sex ☐ M ☐ F	5. Marital Status ☐ Married ☐ Single

6. Mailing Address (Street)	City	County of physical residence	State	Zip

7. Home Phone	Work Phone	Cell Phone	Preferred Phone

8. State Agency Code	9. Hire Date	10. Effective Coverage/Change Date	11. Reason for Change	12. Annual Salary $

Section B: MEDICAL

	Single	Employee + Sp/Partner	Employee + Child/Children	Family
☐ Waiver of Medical/Pharmacy - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Presbyterian Health Plan - HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - HMO	☐	☐	☐	☐
☐ Blue Cross Blue Shield of New Mexico - PPO	☐	☐	☐	☐

Section C: DENTAL

	Single	Employee + Sp/Partner	Employee + Child/Children	Family
☐ Waiver of Dental - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Enroll me in Delta Dental of New Mexico	☐	☐	☐	☐

Section D: VISION

	Single	Employee + Sp/Partner	Employee + Child/Children	Family
☐ Waiver of Vision - *An "X" in this box waives my enrollment in this benefit plan.*				
☐ Enroll me in Vision Service Plan (VSP)	☐	☐	☐	☐

Section E: LIFE

Enrollment in Basic Life, for State Employees, is automatic.

Additional (Supplemental) Life:
Coverage is available up to 3X your annual salary - NOT to exceed $400,000 for New Hires ONLY.
Enrollment/increase (outside of New Hire) is available, not to exceed $400,000; Evidence of Insurability (EOI) must be submitted:
http://www.standard.com/mybenefits/newmexico_rmd/evidence.html

Supplemental Life *(select level)* ☐ SUP 1 ☐ SUP 2 ☐ SUP 3 ☐ SUP 4 ☐ SUP 5 ☐ No Supplemental Life ☐ Drop Current Supplemental Life
May need Evidence of Insurability (EOI) form

☐ Dependent Life *(Children do not require EOI. Spouse/DP : EOI form is required if enrollment in Dep Life is being elected outside of 31 days from the marriage/affidavit or new hire.)*

Section F: DISABILITY (For Employee Only)

☐ Waiver of Disability - *An "X" in this box waives my enrollment in this benefit plan.*

☐ Enroll me in Disability - Check with your HR Rep for Disability Guidelines

Section G: IF YOU MADE A SELECTION ABOVE, LIST ALL DEPENDENTS TO BE COVERED, INCLUDING YOUR SPOUSE or DOMESTIC PARTNER.

NOTE: New Hires/Qualifying Events: proof of dependency documentation, for dependents not previously covered under any benefit coverage, must be faxed to Erisa at (505) 244-6009 with the enrollment form

Indicate with an A (add), D (drop), C (continue coverage), NA (not applicable) for all names listed below.

Relationship Codes: 1=Employee, 2=Spouse, 3=Son, 4=Daughter, 5=Domestic Partner, 6 =Domestic Partner Child

Med Pkg	Dental	Vision	Dis	Life/ Dep Life	SSN / ITIN	Name (Last Name, First Name, MI)	Sex M or F	Rel. Code 1- 6	Date of Birth
					Employee				
					Spouse/Domestic Partner				
					Dependent				
					Dependent				
					Dependent				
					Dependent				
					Dependent				
					Dependent				

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, Insurance Fraud will be prosecuted to the fullest extent of the law and will prohibit access to RMD Benefits in the future.

I have had the opportunity to ask questions about my benefit options and my enrollment elections reflect my informed decisions.

I understand that once I submit my enrollment information, including any waiver, I will have limited opportunities to change my enrollment elections other than during the open/switch enrollment in the fall of each year for benefit plan years starting each January 1st.

I reviewed the information I provided in this enrollment before submitting and I confirm that the information accurately reflects my elections.?

I authorize premium deductions to be taken from my salary per NMSA § 10-7-5 to pay for the benefits I have elected. I understand those deductions shall be taken from my earnings on a pre-tax basis unless I submit the required POP waiver form.

I understand that services will be available subject to exclusions, limitations, and conditions described in the summary plan descriptions (found on each carrier's website). I authorize any hospital, physician, dentist, or other health care provider to furnish, medical information regarding me and my dependents necessary to process claims. I authorize the carrier to coordinate benefits and/or reimbursements with other health or dental plans or insurance companies. I certify that the above information is correct to the best of my knowledge and belief.

The State's Group Benefits Plan is required by Federal Law to maintain and protect the privacy of your health information and provide you with notice of its legal duties and privacy practices. The privacy notice is posted at https://www.mybenefitsnm.com/Documents/HIPAA_Privacy_Notice.PDF on the mybenefits.com website. If you have any questions regarding this notice or the privacy of your health information, please contact RMD at PO Box 6850, Santa Fe, NM 87502, or by telephone at 505-827-0450.

Signature _____ Submission Date

Privacy Policies and Procedures For
The Risk Management Division, General Services Department
State of New Mexico

Purpose

The purpose of these policies and procedures is to provide formal guidance to employees of the Risk Management Division (RMD) and Erisa Administrative Services, Inc. (Erisa) with regard to the receiving, handling, and disseminating of protected healthcare information (PHI) as it pertains to the administration of health plans.

The primary guiding factor behind these policies and procedures is to ensure that PHI is only used and disseminated appropriately. Specifically, that PHI be used only in the activities related to the administration of the health plans and NOT be disseminated such that the information may be used for other types of personnel decisions such as promotions, terminations, etc.

All policies and procedures of RMD and Erisa are public documents and are to be placed on permanent file with RMD and Erisa and made available upon request.

Scope

These guidelines apply to all RMD and Erisa Administrative Services, Inc. (Erisa) and/or employees engaged in health plan administration who, through the course of their normal duties, may come into contact with PHI.

PHI is defined by Federal Law to be individually identifiable health information transmitted or maintained by a covered entity, regardless of form. As this pertains to RMD and Erisa, PHI will be in the form of employee appeals regarding decisions made by our health plan vendors, or PHI from the vendors themselves. Not all appeals contained PHI, though.

These guidelines apply to benefit plan administrators but there are exceptions for worker's compensation or disability programs, are not subject to the same requirements.

Identification Of Affected Workforce Members

All employees, be they full or part-time, temporary or permanent, of the Employee Benefits Bureau (EBB) may come into contact with PHI and are, therefore, subject to these policies and procedures.

The Deputy Director of RMD, by means of his/her oversight of EBB, may come into contact with PHI and is, therefore, subject to these policies and procedures.

The Director of RMD, by means of his/her oversight of the Division, may come into contact with PHI related to health plan administration and is, therefore, subject to these policies and procedures.

The Cabinet Secretary of the General Services Department, by means of his/her oversight of the Department, may come into contact with PHI related to health plan administration and is, therefore, subject to these policies and procedures.

Any other employee of the State of New Mexico who comes into contact with PHI designated for the use of health plan administration is subject to these policies and procedures.

Acceptance of PHI

PHI, according to law, may be received in any form. This includes paper, emails, faxes, and conversationally (oral).

The source of PHI may only be (1) a plan member seeking assistance in obtaining payment from a health plan for a service or supply or (2) from a business associate assisting RMD in the guidelines. Any such business associates will have in place contractual requirements mandating compliance to the same HIPAA regulations.

Any actionable request must be received in a written format. In other words, if PHI is received orally, it must be followed up with written documentation for any action to be taken.

Upon acceptance, all material containing PHI will be documented in a central location and assigned to a specific individual for disposition.

Handling PHI

PHI, if provided by the member, may be used by the appropriate personnel to assist in making a payment determination.

PHI may not be used in any way to assist in making an eligibility determination. Eligibility requirements have been established without regard to an individual's health status.

Additional PHI may not be requested by RMD from any source other than the member.

Disseminating and/or Disclosure of PHI

PHI shall not be disseminated to other areas of State or Local Government except as provided in the following Exceptions paragraph.

PHI shall not be disseminated to entities outside of State or Local Government except as provided in the following Exceptions paragraph.

PHI shall only be disseminated beyond the assigned individual within RMD in order to facilitate health plan administration. Such dissemination shall only be with and limited to the minimum number of individuals necessary for plan administration.

No PHI shall be disseminated on a routine or recurring basis except as provided in the following Exceptions paragraph.

Members may request to view their own PHI. As outlined, PHI will only be on file at RMD if sent by the member. PHI will only be provided after due diligence is applied to determine requestor's identity. All other requests for PHI will be denied except as provided in the following Exceptions paragraph.

Exceptions to PHI Dissemination and/or Disclosure

PHI may be disseminated without member consent in the following circumstances:

To facilitate payment with a health plan:. If an appeal is received and it is clear that information is received by RMD which was not available to the determining health plan, this information may be disseminated to the health plan for their review and possible payment of denied services. If, after review of an appeal, RMD determines that a service or product should be paid for by the plan, PHI should not be disseminated to the health plan. Once in health plan possession, PHI is subject to published health plan privacy guidelines.

During a health emergency or when you are incapacitated, we will use our professional judgment to decide if sharing your health information is in your best interest.

We will disseminate PHI when required by federal, state or local law.

If law enforcement officials ask, PHI may be disseminated under the following circumstances: to identify or locate a fugitive or missing person, to disclose information about a death RMD believes may be the result of a crime, to disclose information RMD believes may be related to a crime on State of New Mexico property, or as required by a court order, subpoena, warrant, summons or other legal request.

PHI may be disclosed if such disclosure would prevent or lessen a serious and immediate threat to the health or safety of any person or the general public.

PHI may be disclosed with federal officials for national security purposes as authorized by law.

PHI may be disclosed as required by worker's compensation laws.

PHI may be disclosed to the Secretary of the U.S. Department of Health and Human Services (HHS) when HHS requests the health information to determine if we are following privacy law.

Providing Notice of Privacy Practices

Notice of privacy practices shall be communicated to all State Employees upon implementation.

Notice of privacy practices shall include all employee rights afforded under these policies and procedures.

Notice of privacy practices shall be communicated no less than annually thereafter.

Form #11: HIPAA Privacy Policies and Procedures

Privacy Policies and Procedures For
The Risk Management Division, General Services Department
State of New Mexico

Purpose
The purpose of these policies and procedures is to provide formal guidance to employees of the Risk Management Division (RMD) and Erisa Administrative Services, Inc. (Erisa) with regard to the receiving, handling, and disseminating of protected healthcare information (PHI) as it pertains to the administration of health plans.

The primary guiding factor behind these policies and procedures is to ensure that PHI is only used and disseminated appropriately. Specifically, that PHI be used only in the activities related to the administration of the health plans and NOT be disseminated such that the information may be used for other types of personnel decisions such as promotions, terminations, etc.

All policies and procedures of RMD and Erisa are public documents and are to be placed on permanent file with RMD and Erisa and made available upon request.

Scope
These guidelines apply to all RMD and Erisa Administrative Services, Inc. (Erisa) and/or employees engaged in health plan administration who, through the course of their normal duties, may come into contact with PHI.

PHI is defined by Federal Law to be individually identifiable health information transmitted or maintained by a covered entity, regardless of form. As this pertains to RMD and Erisa, PHI will be in the form of employee appeals regarding decisions made by our health plan vendors, or PHI from the vendors themselves. Not all appeals contained PHI, though.

These guidelines apply to benefit plan administrators but there are exceptions for worker's compensation or disability programs, are not subject to the same requirements.

Identification of Affected Workforce Members

All employees, be they full or part-time, temporary or permanent, of the Employee Benefits Bureau (EBB) may come into contact with PHI and are, therefore, subject to these policies and procedures.

The Deputy Director of RMD, by means of his/her oversight of EBB, may come into contact with PHI and is, therefore, subject to these policies and procedures.

The Director of RMD, by means of his/her oversight of the Division, may come into contact with PHI related to health plan administration and is, therefore, subject to these policies and procedures.

The Cabinet Secretary of the General Services Department, by means of his/her oversight of the Department, may come into contact with PHI related to health plan administration and is, therefore, subject to these policies and procedures.

Any other employee of the State of New Mexico who comes into contact with PHI designated for the use of health plan administration is subject to these policies and procedures.

Acceptance of PHI

PHI, according to law, may be received in any form. This includes paper, emails, faxes, and conversationally (oral).

The source of PHI may only be (1) a plan member seeking assistance in obtaining payment from a health plan for a service or supply or (2) from a business associate assisting RMD in the guidelines. Any such business associates will have in place contractual requirements mandating compliance to the same HIPAA regulations.

Any actionable request must be received in a written format. In other words, if PHI is received orally, it must be followed up with written documentation for any action to be taken.

Upon acceptance, all material containing PHI will be documented in a central location and assigned to a specific individual for disposition.

Handling PHI

PHI, if provided by the member, may be used by the appropriate personnel to assist in making a payment determination.

PHI may not be used in any way to assist in making an eligibility determination. Eligibility requirements have been established without regard to an individual's health status.

Additional PHI may not be requested by RMD from any source other than the member.

Disseminating and/or Disclosure of PHI

PHI shall not be disseminated to other areas of State or Local Government except as provided in the following Exceptions paragraph.

PHI shall not be disseminated to entities outside of State or Local Government except as provided in the following Exceptions paragraph.

PHI shall only be disseminated beyond the assigned individual within RMD in order to facilitate health plan administration. Such dissemination shall only be with and limited to the minimum number of individuals necessary for plan administration.

No PIII shall be disseminated on a routine or recurring basis except as provided in the following Exceptions paragraph.

Members may request to view their own PHI. As outlined, PHI will only be on file at RMD if sent by the member. PHI will only be provided after due diligence is applied to determine requestor's

identity. All other requests for PHI will be denied except as provided in the following Exceptions paragraph.

Exceptions to PHI Dissemination and/or Disclosure

PHI may be disseminated without member consent in the following circumstances:

To facilitate payment with a health plan:.If an appeal is received and it is clear that information is received by RMD which was not available to the determining health plan, this information may be disseminated to the health plan for their review and possible payment of denied services. If, after review of an appeal, RMD determines that a service or product should be paid for by the plan, PHI should not be disseminated to the health plan. Once in health plan possession, PHI is subject to published health plan privacy guidelines.

During a health emergency or when you are incapacitated, we will use our professional judgment to decide if sharing your health information is in your best interest.

We will disseminate PHI when required by federal, state or local law.

If law enforcement officials ask, PHI may be disseminated under the following circumstances: to identify or locate a fugitive or missing person, to disclose information about a death RMD believes may be the result of a crime, to disclose information RMD believes may be related to a crime on State of New Mexico property, or as required by a court order, subpoena, warrant, summons or other legal request.

PHI may be disclosed if such disclosure would prevent or lessen a serious and immediate threat to the health or safety of any person or the general public.

PHI may be disclosed with federal officials for national security purposes as authorized by law.

PHI may be disclosed as required by worker's compensation laws.

PHI may be disclosed to the Secretary of the U.S. Department of Health and Human Services (HHS) when HHS requests the health information to determine if we are following privacy law.

Providing Notice of Privacy Practices

Notice of privacy practices shall be communicated to all State Employees upon implementation.

Notice of privacy practices shall include all employee rights afforded under these policies and procedures.

Notice of privacy practices shall be communicated no less than annually thereafter.

Form #12: Employee Notice of Privacy Practices (must be read & signed by employee upon hire)

Risk Management Division – Employee

Notice of Privacy Practices

Many people are worried today about how their personal health information is being used – and with very good reason. Information about your health is a very personal thing and its improper use can leave one feeling violated and victimized. The Risk Management Division (RMD) and Erisa Administrative Services, Inc. (Erisa), are equally concerned. This notice details how your medical information may be used and disclosed as well as how you can gain access to this information.

RMD and Erisa are required by federal law to maintain and protect the privacy of your health information and provide you with notice of its legal duties and privacy practices. If you have any questions regarding this notice or the privacy of your health information, please contact RMD/Erisa at PO Box 6850, Santa Fe, NM 87502-0110, or by telephone at 1-855-618-1800.

When Your Health Information Can Be Used or Disclosed by RMD and Erisa Administrative Services, Inc. (Erisa)

RMD and Erisa have always been aware of the sensitivity of protected (or personal) health information (PHI). As such, RMD/Erisa has limited the amount of PHI it receives in its facilities. In addition, RMD/Erisa has ensured that each of its business associates (i.e. health plans) has committed to the same stringent privacy guidelines in dealing with your PHI.

The following categories describe the ways that RMD and Erisa may use and disclose your PHI.

1. Payment Functions – RMD and Erisa may use or disclose your PHI to facilitate payment for the treatment and services you receive. For example, if you send PHI to RMD as part of an appeal of a health plan decision, RMD may share that PHI with the health plan in order to facilitate the payment of the charges should they be determined to be covered under your plan.

2. Health Care Operations – RMD and Erisa may use or disclose your PHI in order to conduct insurance-related activities. These activities include, but are not limited to, premium ratings, quality assurance processes (audits), fraud and abuse detection and investigation.

3. Legal Requirements / Law Enforcement – RMD and Erisa may use or disclose your PHI, as required by law, in compliance with a court order or subpoena.

4. Public Health / Public Safety – RMD and Erisa may use your PHI to prevent or lessen a serious and immediate threat to the health or safety of any person or the general public.

5. Health Oversight Activities – Your PHI may be disclosed to health oversight agencies, such as the New Mexico Department of Insurance (DOI), during the course of audits,

investigations, inspections or other proceedings related to the oversight of the health care system.

6. Coroners, Medical Examiners and Funeral Directors – RMD and Erisa may disclose your PHI to coroners, medical examiners and funeral directors.

7. Organ and Tissue Donation – RMD and Erisa may disclose your PHI to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

8. National Security – RMD and Erisa may disclose your PHI for military, national security, prisoner, and government benefits purposes.

9. Worker's Compensation – RMD and Erisa may disclose your PHI, as necessary, to comply with worker's compensation or similar laws.

10. Marketing – RMD and Erisa may use your PHI in order to contact you about health-related benefits and services that may be of interest to you.

When Your Health Information Cannot Be Used or Disclosed by RMD or Erisa

RMD and Erisa Administrative Services, Inc.(Erisa) may not use or disclose your health information without your written authorization, except as designated above in this notice. If you authorize the use PHI by RMD/Erisa for another purpose, you may revoke your authorization in writing at any time. This revocation, however, cannot undo any disclosures that were already made with your permission.

Your Rights Regarding Your Health Information

1. Right to Request Restrictions – You have the right to request restrictions on the way your PHI is used and disclosed in certain situations. RMD and Erisa are not required to agree to the restrictions but will apply them where prudent and reasonable. If you would like to make a request for restrictions, you must do so in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

2. Right to Request Confidential Communications – You have the right to receive your PHI through a reasonable alternative means or at an alternative location for confidentiality purposes. Be sure to include your "alternative location" request in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110. We are not required to agree to all such requests.

3. Right to Inspect and Copy – You have the right to inspect and copy your PHI that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110. We may charge you a reasonable fee to cover expenses associated with your request.

4. Right to Request Amendment – You have the right to request that RMD and Erisa amend your PHI that you believe is incorrect or incomplete. Upon review, should RMD/Erisa deny your requested amendment, you will be provided with information about the denial and how

it may be appealed. To request an amendment, please do so in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

5. Right to Know to Whom Your PHI Has Been Disclosed – You have a right to receive a list or "accounting of disclosures" of your PHI, with the exception of disclosures made for payment functions or health care operations. To request this accounting, please submit your request in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

6. Right to Review This Notice – You have a right to receive a paper copy of this Privacy Notice at any time. To obtain a paper copy of this Notice, send your written request to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

Should you wish to discuss these rights in more detail, or if you would like to exercise one or more of these rights, contact RMD/Erisa at PO Box 6850, Santa Fe, NM 87502-0110 or by telephone at 1-855-618-1800.

Changes to this Notice

RMD reserves the right to amend this Notice of Privacy Practices in the future and to make the new Notice effective for all health information that it maintains. RMD will promptly distribute the new Notice to you whenever a material change is made. Until such time, RMD is required by law to comply with the current version of this Notice.

Complaints

Please direct any complaints about this Notice or about how your PHI is handled, in writing, to RMD at PO Box 6850, Santa Fe, NM 87502-0110. RMD assures you that you will not be retaliated against in any way for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

****

I, the undersigned, have been provided with Risk Management Division's (RMD) Privacy Policies and Procedures as well as the Privacy Notice provided to our membership. Both documents have been explained to me and I am in full understanding of their spirit and intent.

Furthermore, I understand the importance of maintaining the privacy of our membership and will do so as provided by RMD's Policies and Procedures. I recognize that a failure to comply with the policies and procedures may result in disciplinary action as determined by RMD's Privacy Officer.

Employee Signature	Printed Name	Date

Cc: Personnel File
Privacy Officer

MICHELLE LUJAN GRISHAM
GOVERNOR

DUFFY RODRIGUEZ
ACTING CABINET SECRETARY

RANDALL CHERRY
ACTING DIRECTOR
RISK MANAGEMENT

ADMINISTRATIVE SERVICES DIVISION
(505) 476-1857

FACILITIES MANAGEMENT DIVISION
(505) 827-2141

PURCHASING DIVISION
(505) 827-0472

RISK MANAGEMENT DIVISION
(505) 827-2036

STATE PRINTING & GRAPHIC SERVICES BUREAU
(505) 476-1950

TRANSPORTATION SERVICES DIVISION
(505) 827-1958

State of New Mexico
General Services Department

AFFIDAVIT OF DOMESTIC PARTNERSHIP

As required by Executive Order 2003-010, this affidavit must be used to apply for

domestic partner benefits and must be filed with the state employee's human resources office.

A. DECLARATION OF DOMESTIC PARTNERSHIP

I,_____, declare that I am in a domestic partnership with
(Print State Employee's Name)

_____. Further, we declare that:
(Print Domestic Partner's Name)

1. We are in an exclusive and committed relationship for the benefit of each other, and our relationship is the same as, or similar to, a marriage relationship in the State of New Mexico.
2. We share and have shared together for 12 or more consecutive months a common, primary residence.
3. We are jointly responsible for each other's common welfare and we share financial obligations.
4. Neither of us is married or a member of another domestic partnership; nor have either of us been so during the past 12 months.
5. We are both at least 18 years of age.
6. We are both legally competent to sign this Affidavit of Domestic Partnership.
7. We are not related by blood to a degree of closeness that would prevent us from being married to each other in the State of New Mexico.

B. BENEFITS FOR THE ELIGIBLE DEPENDENTS CHILDREN OF THE DOMESTIC PARTNER

Domestic partner benefits are also available to the domestic partner's children, provided, however, that the child is primarily dependent upon the employee or domestic partner for support and is an eligible dependent child because:

1. Either of the domestic partners is the biological parent of the child;
2. Either or both partners are adoptive parents of the child; or
3. The child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or by court order (excludes foster children).

We declare that the following named individual(s) is/are eligible dependent child(ren):

_____
(For each Eligible Dependent Child, list the child's name and describe the relationship to the Domestic Partner)

_____

_____

C. EXCLUSIONS

Except for the eligible individuals named in Section B above, the following persons are not covered by Domestic Partner benefits and are not considered eligible dependents: parents, foster children, mere roommates, and other relatives who are related to the state employee to such a degree of closeness that marriage would be prohibited in the State of New Mexico.

D. ACKNOWLEDGMENTS

1. By signing this Affidavit of Domestic Partnership, we agree to notify the human resources office at the state employee's job in writing within 31 days (a) of any change in our status as domestic partners when any of the items in the Declaration

of Domestic Partnership (paragraph, A above) no longer apply, (b) because we wish to terminate our domestic partnership (termination notice must be done using the Risk Management Division form "Affidavit of Termination of Domestic Partnership"), or (c) in the event a dependent ceases to meet the eligibility requirements for benefit coverage.

2. We understand that the value of insurance benefits provided to the domestic partner is considered by the federal Internal Revenue Service as taxable income to the employee, that the value thereof is subject to social security and federal income tax withholding, and that current state tax laws require state income tax withholding as well.

3. We understand that the State of New Mexico will pay its portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is paid for similar benefit premium portions paid for spouses and dependents of married persons covered by the state employee's benefits program, and that the state employee is required to pay their portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is required for similar benefit premium portions that married state employees pay for spouses and dependents.

4. We acknowledge that we are hereby advised to seek competent legal advice about present and future financial obligations we may be undertaking before we sign this Affidavit of Domestic Partnership.

5. We understand that at any time we may be requested in writing by the Risk Management Division Director to provide reasonable written proof that we are jointly responsible for the common welfare of each other, that we share financial obligations, and/or to show that the named dependents, if any, are eligible for benefits coverage, and that if we fail to provide such requested proof, then the domestic partner or dependent benefits can be denied or terminated.

6. WE UNDERSTAND THAT ANY MISREPRESENTATION OF FACT MADE IN THIS AFFIDAVIT OF DOMESTIC PARTNERSHIP MAY RESULT IN LOSS OF BENEFITS AND/OR DISCIPLINARY ACTION, AND THAT AS A RESULT OF SUCH MISREPRESENTATION THE STATE EMPLOYEE MAY BE REQUIRED TO REIMBURSE THE STATE OF NEW MEXICO FOR ANY COST FOR PROVIDING BENEFIT COVERAGE OR FOR PROVIDING THE ACTUAL BENEFITS, SUCH COSTS INCLUDING, AMONG OTHER THINGS, ATTORNEY'S FEES.

E. NOTARIZATION

We affirm, under penalty of perjury, that the assertions in this Affidavit of Domestic Partnership are true and correct. *(Both partners must sign this legal document in the presence of a Notary Public.)*

Signature of State Employee	(Print State Employee's Name)
Signature of Domestic Partner	(Print Domestic Partner's Name)

Common Residence Address	City	State	Zip Code
Mailing Address	City	State	Zip Code

STATE OF NEW MEXICO)
)
ss.
COUNTY OF_____)
(County Name)

SUBSCRIBED AND SWORN to this_____day of_____20____, by

_____, an employee of the State of New Mexico, and
(Print State Employee's Name)

_____, the State Employee's Domestic Partner.
(Print Domestic Partner's Name)

My Commission Expires:_____ _____
Notary Public

Para asistencia en español con este formulario, por favor llame a Erisa al 1-855-618-1800

Enrollment & Waiver-NM

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Division level	Account number/unit number
New Mexico Administrative Office of the Courts	ALL MEMBERS	

Member information

Name		Social security number	
Mailing address (street)		Birth date	☐ male ☐ female
(City)	(State)		(ZIP code)
Date employed full-time	Hours worked per week	Job occupation/class	Location
Email address		Home number	Mobile number
Salary (for owners, include business income)	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly		
Employer ZIP code 87501	Employer county SANTA FE		

Coverage	Employee	Spouse or Domestic Partner[3]	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Voluntary term life benefit amount: $10,000 increments up to $500,000	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**
Short term disability	☐ Elect ☐ Decline		
Long term disability	☐ Elect ☐ Decline		

Voluntary term life beneficiary designation (Complete if electing voluntary term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Contingent beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

The right to make future changes is reserved by the employee. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you designated a minor child(ren) as your beneficiary, complete the Uniform Transfers to Minors Act form (GP55229).

Eligible dependent information (Complete if you are electing benefits for your spouse or Domestic Partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ domestic partner
		☐ male ☐ female		☐ child ☐ foster child[1] ☐ disabled child[2]
		☐ male ☐ female		☐ child ☐ foster child[1] ☐ disabled child[2]
		☐ male ☐ female		☐ child ☐ foster child[1] ☐ disabled child[2]
		☐ male ☐ female		☐ child ☐ foster child[1] ☐ disabled child[2]

[1]If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court?
☐ yes ☐ no

[2]When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or Domestic Partner employed by this company?
☐ yes ☐ no

[3]NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60469).

Member agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll until the next open enrollment.
- If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy requires my contribution, I authorize to withdraw from my bank account using a separate form.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

- I understand collection of social security numbers for myself and/or my dependents will be used by Principal Life Insurance Company only as allowed by law.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for coverage. Information will not be used for any purposes prohibited by law.
- I understand that as the member, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X_____**Date signed** _____

Instructions

After this form is completed and signed:

- Employee retains a copy of the form, and
- Enrollment is submitted to Principal Life:
  - email the form to danine@fincepts.com
  - Fincepts submits the data to Principal Life.
  -