COA Participating Entities
Accident and Critical Insurance Enrollment and Change Form

1				
Social Security Number	Employee Name: First, Middle Initial, Last		Sent to Vendor ☐	Effective Date
Employee ID	Mailing Address		Birth Date	Hire Date
Gender: ☐ Female ☐ Male	City, State, Zip	Email	Home Phone	Work Phone

2 — EMPLOYER

- ☐ Belen
- ☐ MRGCD
- ☐ Sandoval County
- ☐ SSCAFCA
- ☐ Town of Bernalillo
- ☐ Town of Cochiti Lake
- ☐ Town of Edgewood
- ☐ Town of Mountainair
- ☐ Vill. of Bosque Farms
- ☐ Village of Corrales
- ☐ Village of Cuba
- ☐ Village of Jemez Springs
- ☐ Village of Los Ranchos
- ☐ Village of San Ysidro
- ☐ Village of Tijeras
- ☐ Water Utility Authority

3

Accident Insurance				
☐ Enroll ☐ Add ☐ Cancel	☐ Employee	☐ Employee & Spouse	☐ Employee & Child(ren)	☐ Family

Critical Illness Insurance ☐ $15,000 ☐ $30,000				
☐ Enroll ☐ Add ☐ Cancel	☐ Employee	☐ Employee & Spouse	☐ Employee & Child(ren)	☐ Family

4

Dependent Full Name	Relationship to Employee	Social Security Number	Date of Birth MM-DD-YY	Gender M or F	Address (if different from employee's)	Office Use Eligible?

5

I hereby submit the information on this form as application/change to insurance coverage under a plan contracted by the City of Albuquerque. I have received and read descriptive literature of the insurance plans as they affect this application/change. I understand, accept and agree to abide by the terms and provisions of the city agreement. If I am not applying for coverage when I, or my dependents, are first eligible due to a life event, then I understand that my request for coverage will be denied. I understand that the employer may change my premiums and/or benefits as part of the annual contract renewal process. I authorize my employer to deduct from my earnings the amount required to pay my share of insurance premiums including the recovery of premiums not paid due to retroactive coverage or a period of unpaid leave. In the event of any discrepancy between this form and the policy, the terms of the policy apply.

I understand I must provide documentation of dependent eligibility before their coverage will be effective.

Accepted by	Entered By	Checked By	Specify Qualifying Life Event:

X Employee Signature Date

** All highlighted fields must be filled out by employer**

Accident and Critical Illness Premium Tables

Accident Insurance (voluntary)

	Employee	Employee & Spouse	Emloyee & Child(ren)	Family
24 Week	4.10	6.45	6.99	10.94
26 Week	3.78	5.95	6.45	10.09
52 Week	1.89	2.97	3.23	5.05

Critical Illness Insurance (voluntary)

$15,000 Coverage Amount				
	Employee	Employee & Spouse	Emloyee & Child(ren)	Family
24 Week	12.42	18.30	13.62	19.70
26 Week	11.46	16.89	12.57	18.18
52 Week	5.73	8.44	6.29	9.09

$30,000 Coverage Amount				
	Employee	Employee & Spouse	Emloyee & Child(ren)	Family
24 Week	24.25	35.47	26.29	37.85
26 Week	22.38	32.74	24.27	34.93
52 Week	11.19	16.37	12.13	17.47

NOTE: Enrollment or coverage changes can only be requested during Open Enrollment, or with a Qualifying Life Event.