

Application for Coverage Medicare Carve-Out



To be eligible for the Medicare Carve-Out plan, you must be under age 65 and be enrolled in Medicare Parts A **and** B due to disability.

NOTE: Every person applying for a New Mexico Medical Insurance Pool policy, even if in the same family, must complete a separate application.

If you have questions or need assistance completing this application, please contact 1-844-728-7896, TTY 1-844-728-7897 or email info@nmmip.org

P.O. Box 1090
Great Bend, KS 67530
1-844-728-7896
TTY 1-844-728-7897
www.nmmip.org

1. APPLICANT INFORMATION						
Last Name	First Name	MI	Age	Birth Date (MM/DD/YYYY) ____/____/____	Social Security Number ____-____-____	
Residence Address (Physical address required)		City			State	Zip
Mailing Address		City			NM	
Billing Address (if different than mailing)		City				
Email Address (optional)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone	Cell Phone	Work Phone		
I am a resident of the state of New Mexico.				<input type="checkbox"/> Yes <input type="checkbox"/> No		
I understand the first month's premium must be included with the application.						

2. Qualifying Conditions

Please answer every question

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Yes</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> | <p>No</p> <p><input type="checkbox"/> I am under 65 years of age and am enrolled in Medicare due to a disability.</p> <p><input type="checkbox"/> I have Medicare (copy of your award letter or Medicare Card is required with this application).
Part A Effective Date: _____
Part B Effective Date: _____</p> <p><input type="checkbox"/> I have other insurance (other than Medicare).
If "yes", with what insurance company? _____
When does coverage end? _____ Why is coverage ending? _____</p> <p><input type="checkbox"/> I have been covered by the Pool in the past. Dates of coverage: from _____ to _____
Reason for termination: _____</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Current Medical Conditions:

1. _____ 3. _____
2. _____ 4. _____

I certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until the full initial premium is paid and this application has been approved by the Pool Administrator. I understand that if I obtain or become eligible for health coverage, I will notify the Pool Administrator of the other coverage.

Signature of Applicant Date

Signature of Parent or Legal Guardian Date
(if applicant is under 18 or legally incompetent)

Relationship to Applicant

Make Check payable to:
New Mexico Medical Insurance Pool (NMMIP)

Mail complete application and premium check to:

New Mexico Medical Insurance Pool
P.O. Box 1090
Great Bend, KS 67530

Delivery Address:
Benefit Management, LLC
2015 16th Street
Great Bend, KS 67530

For Broker/Agency Use Only		
If application is completed with agent/state agency assistance, complete the following: (Please Print)		
Agent's Name		
Company Name		
Mailing Address		
City	State	Zip
TIN/SSN#		
Phone #		
Signature		
Date		