Application for Coverage

New Mexico Medical Insurance Pool
"When no one else will help, we're there"

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

Benefit Summary and Premium Rates are available online at www.nmmip.org. If you have questions or need assistance completing this application, please contact 1-844-728-7896 TTY – 1-844-728-7897 or email us at info@nmmip.org

1. APPLICANT INFORMATION

Complete All Sections in Ink

Last Name	First Name	MI	Age	Birth Date (MM/DD/YYYY)	Social Security Number
				_____/_____/_____	_____-_____-_____

Residence Address (Physical address required)	City	State	Zip
		NM	

Mailing Address	County

Billing Address (if different than mailing)	Cell Phone

Email Address	Gender	Home Phone	Work Phone
	❑ M ❑ F		

I am a resident of the State of New Mexico. ☐ YES ☐ NO

Do you currently use or have you ever used tobacco in any form? ☐ YES ☐ NO

2. REQUESTED COVERAGE START DATE AND DEDUCTIBLE OPTIONS

2.a What **month** are you requesting your New Mexico Medical Insurance Pool (Pool) insurance coverage to begin?

_____

Coverage is effective the 1st of the month following receipt of an application. You will be notified of your coverage start date.

2.b Please select a deductible amount:	❑ $500	❑ $1,000	❑ $2,000	❑ $5,000

3. MEDICAL CONDITIONS (OPTIONAL)

List all prior health conditions:	Date of diagnosis:

4. PROOF OF ELIGIBILITY – See the last page for acceptable documentation.

To help us determine if you meet eligibility criteria for either the Pool's guidelines or the guidelines established in the Health Insurance Portability and Accountability Act (HIPAA), please answer all questions in 5.1 and 5.2 :

5.1 General Eligibility

Yes	No	
❑	❑	I applied for comprehensive health insurance and received a notice of rejection from an insurance carrier.
❑	❑	My premium rate for in-force or applied-for ***individual*** comprehensive health insurance coverage exceeds the "Qualifying Rate" *(posted on www.nmmip.org)* of the Pool's deductible plan nearest my current deductible for my age, tobacco status, and geographical area.

5.2 Eligibility under Portability Criteria (HIPAA)

To be eligible under Health Insurance Portability & Accountability Act (HIPAA) criteria, you must answer yes to the first three (3) questions and provide certificate(s) of creditable coverage or other documentation:

Yes	No	
❑	❑	I have had a minimum of 18 months of continuous coverage with no single gap of more than 95 days,
❑	❑	the last of which was group coverage through an employer or trade union group health plan (may or may not include COBRA), and
❑	❑	I am applying to the Pool within 95 days of my prior coverage ending.

DATES OF PRIOR COVERAGE: _____.

5.3 General Exclusions (please check yes or no for each question)

Yes	No	
❑	❑	I am 65 or older and eligible for Medicare.
❑	❑	I am eligible for Medicaid.
❑	❑	I am eligible for coverage offered by an insurance carrier or the New Mexico Health Insurance Exchange (NMHIX).
❑	❑	I have or am eligible for an employment-related group health plan or Tricare, either as myself or as a family member.
❑	❑	I now have individual comprehensive health coverage. (*If you have limited coverage, you may still qualify.)*
❑	❑	I voluntarily dropped Pool coverage within the last 12 months. My last date of coverage with the Pool was _____.
❑	❑	My most recent health insurance coverage was terminated due to non-payment of premiums or fraud.

If you answer "yes", you will not be eligible for coverage.
Please see the application checklist on the last page of this application for documentation to be included with this application.

5. AFFIRMATION, UNDERSTANDING, AND DISCLOSURE AUTHORIZATION

I understand that I am applying to the New Mexico Medical Insurance Pool for an individual policy of medical, surgical, prescription, and hospital insurance. I also understand that my coverage will become effective on the first of the month following receipt of the application by the Pool, unless I am eligible for HIPAA coverage or continuation. If eligible for HIPAA coverage or continuation, I understand that my coverage will become effective the date that my prior group coverage terminated. I will be responsible for paying premiums from my effective date forward.

I affirm that the foregoing answers on this application are complete and correct. I understand that no coverage will be in effect until this application has been accepted and approved, and the full initial premium has been paid.

_____ **Applicant: Initial here indicating that you have read and understand the above paragraph.**

(A parent/legal guardian/personal representative must initial if the applicant is under 18 years of age or legally incompetent.)

5. AFFIRMATION, UNDERSTANDING, AND DISCLOSURE AUTHORIZATION (continued)

INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. A valid authorization to disclose nonpublic personal information pursuant to 13.1.3.14 NMAC shall be in written or electronic form separate from that used for any other purpose and shall contain all of the following:

(1) The identity of the consumer or customer who is the subject of the nonpublic personal information;

(2) A specific description of the types of nonpublic personal information to be disclosed;

(3) Specific descriptions of the parties to whom the licensee discloses nonpublic personal information, the purpose of the disclosure and how the information will be used;

(4) The signature of the consumer or customer who is the subject of the nonpublic personal information or the individual who is legally empowered to grant authority and the date signed; and

(5) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

B. An authorization for the purposes of this rule shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months.

C. A consumer or customer who is the subject of nonpublic personal information may revoke an authorization provided pursuant to this rule at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

D. A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal information.

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.

Signature of applicant (or parent/legal guardian/personal representative if applicant is under 18 years of age or legally incompetent):	Date
If signed by a personal representative of the applicant, please complete the following:	
Personal representative name (please print)	Relationship to applicant *(attach legal document if other than parent)*

6. AGENT, STATE AGENCY, OR FOUNDATION ASSISTANCE

Insurance agents in your community are able to assist you in completing this application at no cost to you.

I certify by my signature that follows that I have explained eligibility provisions to the applicant and assure that the application is complete and accurate. I have made no statements of benefits, conditions, limitations, or exclusions of the agreement except through written material furnished by the Pool. I have informed the applicant that the effective date of coverage is not guaranteed, and if approved, is determined by the New Mexico Medical Insurance Pool.

Agent/Broker signature certifies that the agent has substantially assisted with the completion of this application and has conducted a final review prior to submission to ensure that the application is complete and accurate. If the application is not complete and accurate, the Pool may choose not to pay the agent fee.

Agent Name		Tax ID Number	
Agency Name		New Mexico License Number	
Street Address	City	State	Zip
Email	Phone	Fax	
Agent Signature		Date	

If enrolling through a State Agency or a Foundation, please complete:

State Agency/Foundation Name		Contact Person	
Address	City	State	Zip
Email	Phone	Fax	

Submit To: New Mexico Medical Insurance Pool (NMMIP)
P.O. Box 1090
Great Bend, KS 67530

APPLICATION CHECKLIST

BEFORE MAILING YOUR APPLICATION, PLEASE COMPLETE THIS CHECKLIST.

_____I have completed every line in Section 1.
_____I have chosen a deductible amount and given a preferred month for my insurance to start in Section 2.
_____I have completely filled out Section 3, giving the information for all people residing at my permanent residence.

Section 5—Proof of Eligibility Documentation

Section 5.1 I have included at least **one** of the following:

_____Rejection notice from an insurance carrier or the New Mexico Health Insurance Exchange (NMHIX) for insurance coverage comparable to that offered by the Pool

Or

_____Quote for comparable insurance from an insurance carrier or the New Mexico Health Insurance Exchange (NMHIX) that exceeds the "Qualifying Rate" of the Pool

Section 5.2 **HIPAA Proof of Eligibility Documentation**
Note: If qualifying HIPPA, please ensure that there is proof of 18 months of coverage

_____Certificate(s) of Creditable Coverage or other documentation from your prior insurance carrier(s) - Individual, Group, COBRA, Medicaid, SCI, etc.

Are You Ready to Submit Your Application?

Note: Only Originals will be accepted to approve the application for coverage – No Copies or Faxes

Faxed Applications may be submitted to guarantee an effective date only

Original Application, Supporting Documents and Payment must be submitted before the Application is approved.

Fax: 620-793-1199

Yes	No	
☐	☐	Is the application signed?
☐	☐	Have you filled out the application checklist (above)?
☐	☐	Have you attached all the required documentation? (see application checklist)
☐	☐	Have you included a check for the first month's premium payable to NMMIP? *(Premium rates are posted on www.nmmip.org)*