New Mexico Medical Insurance Pool Termination Request

Note: Insurance agents are available to assist you at no cost.

Please cancel my coverage with the New Mexico Medical Insurance Pool effective ____________________
mm/dd/yyyy

Reason (provide proof):	Effective Date (mm/dd/yyyy):
☐ Obtained coverage through the Exchange	_____________________
☐ Obtained coverage through Centennial Care	_____________________
☐ Obtained coverage through the Commercial Market	_____________________
☐ Qualified for Medicare	_____________________
☐ Moved out of State	
☐ Other (Please specify) ___________________________________	

____ _________________________________
Signature Date

Printed name __________________________________ Policy # __ __ __ __ __

Address __________________________________

City, State, Zip __________________________________

Telephone # __________________________________

By my signature above, I certify that I have received assistance from the following agent:

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

Agent signature certifies that the agent has substantially assisted the individual listed above with acquisition of other health insurance coverage. If it is determined that the agent did not assist the above named individual, the Pool may choose not to pay the agent fee.

Mail:
New Mexico Medical Insurance
Pool P.O. Box 780548
San Antonio, TX 78278
or
Fax: 210-239-8449
nmmip_eligibility@90degreebe
nefits.com