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

Application Checklist

To apply for New Mexico Medical Insurance Pool (NMMIP) coverage, complete and submit the Application for Coverage with this checklist, supporting documents, and first premium payment. *Each family member applying for coverage must complete a separate Application for Coverage and Application Checklist.*

You will be notified once a decision regarding your application has been made. For assistance, contact us at 1-866-306-1882 or email NMMIP_Eligibility@90degreebenefits.com.

Section 1: Applicant Information

- ☐ If Power of Attorney listed (POA), provide documentation with your application submission.
- ☐ **Provide proof of residency** (lease agreement, mortgage statement, utility bill, voter registration, bank or credit card statement, or another document) with your application submission.

Section 2: Coverage Start Date & Deductible

- ☐ I selected a deductible amount and my preferred month for coverage to begin.

Section 3: Proof of Eligibility

- ☐ **Provide *one of* the following documents** for proof of eligibility:
  - Rejection Notice or Broker Attestation: If you were denied insurance coverage or are ineligible for any other form of major medical health insurance.
  - Quote: If you received a quote for comparable insurance from an insurance carrier or NMHIX that exceeds the Qualifying Rate of NMMIP.
- ☐ If you qualify under HIPPA as described in this section, provide:
  - Documentation of Prior Coverage: Proof of coverage from your previous insurance carrier(s) such as Individual, Group, COBRA, Medicaid, SCI, etc. Ensure documentation shows 18 months of continuous coverage.

Section 4: Medical Information

- ☐ I noted my Primary Care Physician and/or Specialist.
- ☐ I marked or listed my medical conditions and number of medications.

Section 5: Agent, State Agency/Foundation, Third Party Sponsor

- ☐ If I am working with a broker, state agency, or third party sponsor, I completed this section.

Section 6: Premium Payment Information

- ☐ I understand that my first premium payment or ACH Form is required to be considered for coverage.
- ☐ If an ACH option selected, provide a completed Agreement for Preauthorized Payments (ACH Form).
- ☐ If Money Order or Check selected, provide payment.

Section 7: Affirmation, Understanding & Disclosure Authorization

- ☐ I understand that my application cannot be processed if it is not completed **and** signed.
- ☐ I have initialed and signed the application.

- ☐ If applicable, provide your completed Low Income Premium Program (LIPP) Application.

Submit this checklist with the Application for Coverage, all supporting documents as listed above, first premium payment or ACH Form, and LIPP Application (if applicable) by mail, email, or fax. **If paying first premium by check or money order, you must MAIL the application and all attachments WITH the payment.**

New Mexico Medical Insurance Pool (NMMIP)

Mail: PO Box 780548, San Antonio, TX 78278

Application for Coverage

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Email: NMMIP_Eligibility@90degreebenefits.com.
Fax: 210-239-8449

To apply for New Mexico Medical Insurance Pool (NMMIP) coverage, **complete all boxes and sections** of this Application for Coverage and the Application Checklist **in ink**. Submit the checklist, application, supporting documents, and first premium payment by mail, email, or fax.

Detailed information about benefits and premium rates is available online at www.nmmip.org. For assistance, contact us at 1-866-306-1882 or email NMMIP_Eligibility@90degreebenefits.com.

Section 1: Applicant Information

- ☐ If multiple family members are applying for coverage, each member must complete a separate Application for Coverage and Application Checklist.
- ☐ If you are applying for the Low Income Premium Program (LIPP), complete the LIPP Application and submit it with this Application for Coverage.

Last Name		First Name		MI
Age	Birth Date (MM/DD/YYYY)	Gender ○ Female ○ Male	Social Security Number (if applicable)	
Residence Address (Physical address required)	City	State NM	Zip	County
Mailing Address (if different than Residence)	City		Zip	County
Home Phone (include area code)	Work Phone (include area code)		Cell Phone (include area code)	
Email Address		Preferred Method of Communication ○ Phone ○ Text ○ Email		Hearing Impaired ○ Yes ○ No
Preferred Language				
○ Emergency Contact OR ○ Power of Attorney (POA) If POA, **attach documentation**.				
Individual or Agency Name	Address		Phone Number	
Are you a resident of the State of New Mexico? If YES, **provide proof of residency** (lease agreement, mortgage statement, utility bill, voter registration, bank or credit card statement, or another document). ○ Yes ○ No				

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Section 2: Coverage Start Date & Deductible

Coverage is effective **on the first day of the month following receipt** of completed application and first premium payment.	
What month would you like your NMMIP coverage to begin:	

Detailed information about benefits and premium rates is available online at www.nmmip.org.

Select a deductible amount for your coverage:

☐ $500	☐ $1,000	☐ $2,000	☐ $5,000

Section 3: Proof of Eligibility

To determine if you meet the eligibility criteria of either NMMIP's guidelines or those established by the Health Insurance Portability and Accountability Act (HIPAA), select YES or NO for **every** question below.

General Eligibility		
☐ YES	☐ NO	I have been denied health insurance coverage.
☐ YES	☐ NO	I am not eligible for any other form of health insurance or Medicaid.
☐ YES	☐ NO	The premium rate for my current or applied-for *individual* comprehensive health insurance coverage exceeds the Qualifying Rate (posted on www.nmmip.org) of NMMIP's deductible plan nearest to my age, tobacco status, and geographical area.
Eligibility under Portability Criteria (HIPAA) To be eligible under HIPAA, you must answer yes to the following three questions and provide documentation.		
☐ YES	☐ NO	I have had a minimum of 18 months of continuous coverage with no single gap of more than 95 days.
☐ YES	☐ NO	My last coverage was group coverage through an employer or trade union group health plan (may or may not include COBRA).
☐ YES	☐ NO	I am applying to NMMIP within 95 days of my prior coverage ending. Dates of Prior Coverage:
General Exclusions (If you answer "yes" to any of the following, you may not be eligible for NMMIP coverage.)		
☐ YES	☐ NO	I am 65 or older and eligible for Medicare.
☐ YES	☐ NO	I am eligible for Medicaid.
☐ YES	☐ NO	I am eligible for coverage offered by an insurance carrier or the New Mexico Health Insurance Exchange (NMHIX).
☐ YES	☐ NO	I have or am eligible for an employment-related group health plan or Tricare, either as myself or as a family member.
☐ YES	☐ NO	I currently have individual comprehensive health coverage. (If you have limited coverage, you may still qualify.)
☐ YES	☐ NO	I voluntarily dropped NMMIP coverage within the last 12 months. My last date of coverage with NMMIP was:
☐ YES	☐ NO	My most recent health insurance coverage was terminated due to non-payment of premiums or fraud.

Refer to the Application Checklist for required documentation.

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Section 4: Medical Information

Do you currently use, or have you used tobacco in any form within the past 12 months?	☐ YES ☐ NO
Are you currently inpatient at a hospital facility?	☐ YES ☐ NO

Name of Hospital:	

If you have a Primary Care Physician (PCP) and/or Specialist, complete the information below.

PCP Name	PCP Phone Number (include area code)
Specialist Name	Specialist Phone Number (include area code)

Check any of the following medical conditions that you have. You may be eligible for additional services.

☐ Artificial Heart Valve	☐ Cancer	☐ Coronary Artery Disease
☐ Cerebral Palsy	☐ Cirrhosis of Liver	☐ Cystic Fibrosis
☐ Diabetes	☐ Multiple Sclerosis	☐ Hepatitis C (Active)
☐ Kidney Failure	☐ Leukemia	☐ Parkinson's Disease
☐ Respiratory Disease	☐ ESRD	☐ Stroke
☐ Organ Transplant	If your medical condition is not listed, please provide:	

How many medications do you take?

Section 5: Agent, State Agency/Foundation, Third Party Sponsor

Insurance agents in your community can assist you in completing this application at no cost to you. Visit www.nmmip.org for a list of brokers.

Agent, broker, state agency, foundation, or third party sponsor of applicant, complete all boxes below.

☐ Agent/Broker ☐ State Agency/Foundation ☐ Third Party Sponsor	Name	☐ Tax ID Number ☐ NM License Number	
Address	City	State	Zip
Email	Phone	Fax	

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Section 6: Premium Payment Information

Select the method of payment for your initial premium (must be included for coverage consideration).
Amount $_____

- ☐ Money Order or Check
- ☐ One-time ACH
- ☐ Monthly ACH

For one-time or monthly ACH, complete and attach Agreement for Preauthorized Payments (ACH Form). If paying first premium by check or money order, you must MAIL the application and all attachments WITH the payment.

Section 7: Affirmation, Understanding & Disclosure Authorization

By initialing below, I acknowledge the following:

- I am applying to the New Mexico Medical Insurance Pool (NMMIP) for an individual policy covering medical, surgical, prescription, and hospital insurance.
- My coverage will start on the first of the month following receipt of my application by NMMIP unless I am eligible for HIPAA coverage or continuation. If eligible for HIPAA coverage or continuation, my coverage will start the date that my prior group coverage ended.
- I will be responsible for paying premiums from my effective date forward.
- I affirm that all answers provided in this application are complete and accurate.
- No coverage will be effective until this application is accepted and approved, and the full initial premium has been paid.
- I have a ten-day period in which I can examine and choose to return the contract to have my premium refunded. If I receive services within that ten-day period, I must pay for those services.

	Initial here to indicate that you have read and understand the information listed above. *A parent/legal guardian/personal representative must initial if the applicant is under 18 years of age or legally incompetent.*

With my signature, I authorize the disclosure of my protected health information as described below:

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 the following:
   1) The identity of the consumer or customer who is the subject of 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 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.

I further acknowledge that 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.

My signature below authorizes disclosure of my protected health information and acknowledgement as described above. Application cannot be processed without signature.

Signature of Applicant *Or parent/legal guardian/personal representative if applicant is under 18 years of age or legally incompetent.*	**Date**
PRINTED NAME of parent/legal guardian/personal representative	Relationship to Applicant *Attach legal document if other than Parent.*

WARNING: 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.

Pursuant to NMAC 13.1.3.20, a consumer or customer may revoke authorization of disclosure of nonpublic personal information at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

Submit this completed and SIGNED Application for Coverage with the Application Checklist, ALL supporting documents, first premium payment, and (if applicable) LIPP Application and/or Agreement for Preauthorized Payments (ACH Form) by mail, email, or fax. **If paying first premium by check or money order, you must MAIL the application and all attachments WITH the payment.**

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