Application for Coverage
Medicare Carve-Out

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

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 NMMIP Policy, even if in the same family, must complete a separate application.

PO Box 780548
San Antonio, TX 78278
1-866-306-1882
www.nmmip.org

If you have questions or need assistance completing this application, please contact 1-866-306-1882 or email NMMIP_Eligibility@90degreebenefits.com.

Section 1: Applicant Information

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				
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				

Section 2: Qualifying Conditions

Please answer every question:		
☐ YES	☐ NO	I am under 65 years of age and enrolled in Medicare due to a disability.
☐ YES	☐ NO	I have Medicare **(copy of your award letter or Medicare Card is required.)** Part A Effective Date: _____ Part B Effective Date: _____
☐ YES	☐ NO	I have insurance other than Medicare. If yes, with what insurance company? _____ When does coverage end? _____ Why is coverage ending? _____
☐ YES	☐ NO	I have been covered by NMMIP in the past. Dates of coverage: from_____ to _____ Reason for termination: _____

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Section 3: 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 4: 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 5: 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.

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

_____ _____ _____ _____

Signature of Applicant | Date | Signature of Parent or Legal Guardian | Date

_____

Relationship to Applicant

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.

If paying first premium by check or money order, you must MAIL the application and all attachments WITH the payment.

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Mail: PO Box 780548, San Antonio, TX 78278

Email: NMMIP_Eligibility@90degreebenefits.com.

Fax: 210-239-8449