

# Application for Coverage



Email: [NMMIP\\_Eligibility@90degreebenefits.com](mailto: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](http://www.nmmip.org). For assistance, contact us at 1-866-306-1882 or email [NMMIP\\_Eligibility@90degreebenefits.com](mailto: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 <input type="radio"/> Female <input type="radio"/> 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 <input type="radio"/> Phone <input type="radio"/> Text <input type="radio"/> Email		Hearing Impaired <input type="radio"/> Yes <input type="radio"/> No	
Preferred Language					
<input type="radio"/> Emergency Contact OR <input type="radio"/> Power of Attorney (POA) If POA, <b>attach documentation</b> .					
Individual or Agency Name		Address		Phone Number	
Are you a resident of the State of New Mexico? If YES, <b>provide proof of residency</b> (lease agreement, mortgage statement, utility bill, voter registration, bank or credit card statement, or another document). <input type="radio"/> Yes <input type="radio"/> No					

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## Section 2: Coverage Start Date & Deductible

Coverage is effective <b>on the first day of the month following receipt</b> 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 <a href="http://www.nmmip.org">www.nmmip.org</a> .			
Select a deductible amount for your coverage:			
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$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		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I have been denied health insurance coverage.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I am not eligible for any other form of health insurance or Medicaid.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	The premium rate for my current or applied-for <i>individual</i> comprehensive health insurance coverage exceeds the Qualifying Rate (posted on <a href="http://www.nmmip.org">www.nmmip.org</a> ) 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.		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I have had a minimum of 18 months of continuous coverage with no single gap of more than 95 days.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	My last coverage was group coverage through an employer or trade union group health plan (may or may not include COBRA).
<input type="checkbox"/> YES	<input type="checkbox"/> 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.)		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I am 65 or older and eligible for Medicare.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I am eligible for Medicaid.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I am eligible for coverage offered by an insurance carrier or the New Mexico Health Insurance Exchange (NMHIX).
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I have or am eligible for an employment-related group health plan or Tricare, either as myself or as a family member.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I currently have individual comprehensive health coverage. (If you have limited coverage, you may still qualify.)
<input type="checkbox"/> YES	<input type="checkbox"/> NO	I voluntarily dropped NMMIP coverage within the last 12 months. My last date of coverage with NMMIP was:
<input type="checkbox"/> YES	<input type="checkbox"/> 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?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you currently inpatient at a hospital facility?		<input type="checkbox"/> YES <input type="checkbox"/> 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.		
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Cancer	<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Cirrhosis of Liver	<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Hepatitis C (Active)
<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> ESRD	<input type="checkbox"/> Stroke
<input type="checkbox"/> 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](http://www.nmmip.org) for a list of brokers.

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

<input type="checkbox"/> Agent/Broker <input type="checkbox"/> State Agency/Foundation <input type="checkbox"/> Third Party Sponsor	Name		<input type="checkbox"/> Tax ID Number <input type="checkbox"/> 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.

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- 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.

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

**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.**

New Mexico Medical Insurance Pool (NMMIP)

**Mail:** PO Box 780548, San Antonio, TX 78278

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