Low Income Premium Program
2026 Application
Medicare Carve-Out

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

The Low Income Premium Program (LIPP) is designed to help persons who qualify for New Mexico Medical Insurance Pool (NMMIP) coverage by offering a reduced premium. Income does not determine NMMIP eligibility. If you meet the LIPP eligibility requirements, you must complete and submit this form with a NMMIP Application for Coverage.
If your premium is paid by a third party who is not a family member, you are not eligible for LIPP. For assistance, contact us at 1-866-306-1882 or email NMMIP_Eligibility@90degreebenefits.com.

Please select one of the following:

- ☐ First time applying for LIPP
- ☐ Required Annual LIPP Recertification, due December 15th (Members who FIRST apply for LIPP between October 1 to December 1 do NOT need to recertify until the following fall.)

To find out if you meet eligibility requirements for LIPP, find your household size and the corresponding yearly income amount in the table below.

Qualifying Income Guidelines Effective 01/01/2026 - 12/31/2026

Household Size	0-199% of 2025 HHS Poverty Guidelines 75% Premium Reduction	200-299% of 2025 HHS Poverty Guidelines 50% Premium Reduction	300-399% of 2025 HHS Poverty Guidelines 25% Premium Reduction
☐ 1	☐ $0 - $31,299	☐ $31,300 - $49,949	☐ $49,950 - $62,599
☐ 2	☐ $0 - $42,299	☐ $42,300 - $63,449	☐ $63,450 - $84,599
☐ 3	☐ $0 - $53,299	☐ $53,300 - $79,949	☐ $79,950 - $106,599
☐ 4	☐ $0 - $64,299	☐ $64,300 - $96,449	☐ $96,450 - $128,599
☐ 5	☐ $0 - $75,299	☐ $75,300 - $112,949	☐ $112,950 - $150,599
☐ 6	☐ $0 - $83,299	☐ $83,300 - $129,449	☐ $129,450 - $172,599

Applicant Information

Last Name	First Name	MI		
Address	City	State NM	Zip	
Home Phone	Work Phone	Cell or Message Phone		
Email Address	NMMIP Member ID (if applicable)			
Last Name	First Name	MI	NMMIP ID Number (if applicable)	
Address	City	State NM	Zip	

Premium Payment Certification

I certify that I, or a member of my family, will be paying my NMMIP coverage premiums.	**Applicant Signature**
If your premium is being paid by a third party who is not a family member, you are not eligible for LIPP.	

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Household Size & Income Verification

To determine if you qualify for a reduced premium, provide information about your household size and last year's total combined income for all persons over age 18 in your household. Even if only one person is enrolled for NMMIP coverage, you must still provide information about the entire household, since the premium reduction eligibility is based on total household size and income.

List all the people in your household. Attach additional sheets, if needed.		
Name	Relationship to Applicant	Date of Birth

Note: You do not need to include income information or verification for any member of your household whose income is from Supplementary Security Income (SSI) and/or Temporary Assistance for Needy Families (TANF) only.

List total annual income amount for adults in your household except as excluded above (from Federal Tax Form 1040)_____.

In Addition,

1. Attach a copy of the previous year's Federal Income Tax forms filed (include certification form if filed electronically) by each household member who had income, except as excluded above, and complete and sign the **Federal Tax Form Affidavit** (Affidavit A) portion of this application **- AND/OR –**
2. If any adult in your household had income, except as excluded above, but were not required to file a Federal Income Tax form, they must complete and sign **Affidavit B – Other Income Source Affidavit** page 3 of this application.

Federal Tax Form and Affidavit A

Attach a copy of the prior year's filed Federal Income Tax forms, including certification form if filed electronically, for each household member who had income (except as excluded above) AND complete and sign **Affidavit A**:

By my signature, I swear or affirm that the attached tax form is a true reflection of my income for calendar year 20____, and is a correct copy of the form provided to the Internal Revenue Service (IRS). I certify that the foregoing answers are true and accurate to the best of my knowledge and belief. I also acknowledge that NMMIP may verify this information with state agencies and other sources.	
Print Name of Applicant	Signature of Applicant
Date	Signature of Parent or Legal Guardian *If applicant under 18 or legally incompetent.*

Other Income Source Affidavit B

If any adult in your household had income (except as excluded above) and was not required to file a Federal Income Tax form, they must complete and sign **Other Income Source Affidavit B** below. Attach additional copies if needed.

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By my signature, I swear or affirm that I am not required to file a Federal Income Tax return for calendar year 20____, and that my income for that calendar year was as noted below.	
Income Source Description for Household	**Income Amount**
	$
	$
TOTAL	$

Print Name	Signature	Date

Home Phone	Work Phone	Cell/Message Phone	Email Address

Income Change Affidavit C

If your current income is different from your most recent tax filing, submit a copy of your Federal Income Tax return AND complete **Income Change Affidavit C** for eligibility consideration according to your current household income.

By my signature, I swear or affirm that my current income for calendar year 20____ is as noted below.	
Reason for Difference between most recent Tax Filing and Current Household Income	**Current Annual Household Income Total**
	$

Print Name of Applicant	Signature of 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.

Submit this completed and SIGNED LIPP Application with the Application for Coverage, ALL supporting documents, first premium payment, 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

Email: NMMIP_Eligibility@90degreebenefits.com.

Fax: 210-239-8449