

**NEW MEXICO MEDICAL INSURANCE POOL
EMPLOYMENT VERIFICATION FORM**

Copies of this form are to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If the applicant/member is a child under the age of 26 and single, the current employer of each of the applicant/member's parents and step-parents (as applicable) must complete this form.

Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's or Parent's Name (if applicable):
Your Signature	Date
Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
How many hours a week does the employee usually work for your business?	
Do you provide group health benefit coverage, either insured or self-insured? <input type="checkbox"/>Yes <input type="checkbox"/>No	
If insured, the name of the insurance company:	
Is coverage available for dependents of the employee? <input type="checkbox"/>Yes <input type="checkbox"/>No	
Is the person, named above as the applicant/member, eligible for your coverage? <input type="checkbox"/>Yes <input type="checkbox"/>No	
If no, please explain:	
Do you pay all or part of the cost of employee coverage for any employees? <input type="checkbox"/>Yes <input type="checkbox"/>No	
If yes, please explain:	
If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? <input type="checkbox"/>Yes <input type="checkbox"/>No	
If yes, can the employee use the amount paid for any other purpose? <input type="checkbox"/>Yes <input type="checkbox"/>No	
If yes, please indicate the other permissible uses:	
Do you pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? <input type="checkbox"/>Yes <input type="checkbox"/>No	

Section B Continued on Other Side

If you do not currently provide coverage, was coverage provided during the last 12 months? Yes No

Date of and reason for coverage cancellation/termination:

If insured, the name and telephone number of insurance company:

Do you intend to provide health coverage for employees in the next 6 months? Yes No

Are you working with an agent or third party administrator to secure or establish group coverage? Yes No

If yes, the name and telephone number of the agent or the TPA:

I understand that:

New Mexico Insurance Code 59A-16-11.1 It is an unfair practice for an insurer or other person to refer an individual employee or an employee's eligible dependent to the plan offered pursuant to the Medical insurance Pool Act [Chapter 59A, Article 54 NMSA 1978] or to arrange for an individual employee or an employee's eligible dependent to apply to the plan, for the purpose of separating that employee or dependent from group coverage provided in connection with the employee's employment.

Under the Patient Protection and Affordable Care Act (Pub. Law 111-148) section 1101, an issuer or employment-based health plan may be responsible for reimbursing the Federal High Risk Pool (FHRP) program for medical expenses incurred by the program for an individual who found to have been encouraged by the issuer to disenroll from the health benefits coverage prior to enrolling for coverage into the FHRP.

Employer's Signature: _____

Title: _____

Date: _____

Printed Name: _____