Application for Coverage

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

Benefit Summary and Premium Rates are available on line at www.nmmip.org
If you have questions or need assistance completing this application, please contact 1-877-5-REFORM (877-573-3676) or email us at info@nmmip.org

PO Box 27049
Albuquerque, NM 87125-7049
www.nmmip.org
info@nmmip.org

1. APPLICANT INFORMATION

Complete All Sections in Ink

Last name	First name	MI	Age	Birth Date (MM/DD/YYYY) ____/____/______	Social Security Number ______-____-______

Residence Address (Physical address required)	City	State **NM**	Zip
Mailing Address		County	
Billing Address (if different than mailing)		Cell Phone	

Email address (optional)	Gender ❑ M ❑ F	Home Phone	Work Phone

I am a resident of the state of New Mexico ❑ YES ❑ NO
I am a citizen or national of the United States or legally present in the United States ❑ YES ❑ NO
Answering this question will help us to determine if you are eligible for the Federal High Risk Pool Program or the State High Risk Program.

2. REQUESTED COVERAGE START DATE AND DEDUCTIBLE OPTIONS

2.a What **month** are you are requesting your Pool insurance coverage to begin?______________________________

Generally, for complete applications received by the 15th of the month, the effective date will be the 1st of the next month. *The Pool will notify you of your actual coverage start date, which may be different from the date you request.*

2.b Please select a deductible amount:	NM or Federal Pool ❑ $500	NM or Federal Pool ❑ $1,000	NM or Federal Pool ❑ $2,000	Available to NM Pool Applicants only ❑ $5,000	Available to NM Pool Applicants only ❑ $7,500	Available to NM Pool Applicants only ❑ $10,000

- Office Use Only -

Effective Date:	Auto-pay form attached? ❑ Y ❑ N	CoCC required? ❑ Y ❑ N
YI___ 8769__ __ __ __ __	Waiver Status:	Meets all Federal Eligibility Criteria? ❑ Y ❑ N

Ck#	Amt $	Group #	Appeal ❑ Y ❑N	2ED ___/___/____

Age	Premium $	Age	Premium $
LIPP %	LIPP Premium $	LIPP %	LIPP Premium $

Citizen or National of the US or legally present in the US ❑ YES ❑ NO

Received date:

Notes:

4/22/11

3. HOUSEHOLD INFORMATION

List all relatives living in your household *(use a separate sheet if needed)*

Name (Last, First, MI)	Gender	Birth Date	Relationship	Employer
	❑ M ❑ F	/ /		
	❑ M ❑ F	/ /		
	❑ M ❑ F	/ /		
	❑ M ❑ F	/ /		
	❑ M ❑ F	/ /		
	❑ M ❑ F	/ /		

Please refer to current income guidelines on the Low-Income application to determine if you qualify for a reduced premium.

4. MEDICAL CONDITIONS

If you do not currently have health insurance, but have one of the following conditions, you must attach a note or letter from a physician stating your condition.
Please check all that apply, then continue on to Section 5:

- ❑ AIDS
- ❑ Alcohol/Drug Abuse
- ❑ ALS (Lou Gehrig's Disease)
- ❑ Angina Pectoris
- ❑ Arteriosclerosis Obliterans
- ❑ Artificial Heart Valve
- ❑ Ascites
- ❑ Cardiomyopathy
- ❑ Cirrhosis of the Liver
- ❑ Coronary Insufficiency
- ❑ Coronary Occlusion
- ❑ Crohn's Disease
- ❑ Cystic Fibrosis
- ❑ Dermatomyositis
- ❑ Diabetes (Insulin dependent)
- ❑ Friedreich's Disease
- ❑ Hemophilia
- ❑ Hepatitis C (Active)
- ❑ HIV+
- ❑ Hodgkin's Disease
- ❑ Huntington's Chorea
- ❑ Hydrocephalus
- ❑ Intermittent Claudication
- ❑ Juvenile Diabetes
- ❑ Kidney Failure
- ❑ Lead Poisoning with Cerebral Involvement
- ❑ Leukemia
- ❑ Lupus Erythematosus Disseminate
- ❑ Malignant Tumor (If treated/occurred within previous 4 years)
- ❑ Metastatic Cancer
- ❑ Motor or Sensory Aphasia
- ❑ Multiple or Disseminated Sclerosis
- ❑ Muscular Atrophy or Dystrophy
- ❑ Myasthenia Gravis
- ❑ Myotonia
- ❑ Open Heart Surgery
- ❑ Paraplegia or Quadriplegia
- ❑ Parkinson's Disease
- ❑ Peripheral Arteriosclerosis (If treated within previous 3 years)
- ❑ Polyarteritis (Periarteritis Nodosa)
- ❑ Polycystic Kidney
- ❑ Posterolateral Sclerosis
- ❑ Psychotic Disorders
- ❑ Sickle Cell Anemia
- ❑ Silicosis
- ❑ Splenic Anemia (Tru Banti's Syndrome)
- ❑ Still's Disease
- ❑ Stroke (CVA)
- ❑ Syringomyelia
- ❑ Tabes Dorsalis (Locomotor Ataxia)
- ❑ Thalassemia (Cooley's or Mediterranean Anemia)
- ❑ Topectomy and Lobotomy
- ❑ Wilson's Disease

5. PROOF OF ELIGIBILITY

To help us determine if you meet eligibility criteria for either the State or Federal High Risk Pool, or the Federal guidelines established in the Health Insurance Portability and Accountability Act (HIPAA), please answer all questions below:

5.1 General Eligibility

Yes No
- ❑ ❑ I applied for health insurance and received a notice of rejection.*
- ❑ ❑ I received a notice of health insurance being available ONLY with a rider, waiver, or restrictive provision.*
- ❑ ❑ My premium rate for in-force or applied-for ***individual*** health insurance coverage exceeds the "qualifying rate" *(posted on www.nmmip.org)* of the Pool's deductible plan nearest my current deductible for my age and sex. *(Submit proof.)*
- ❑ ❑ I am switching enrollment from the New Mexico Health Insurance Alliance (NMHIA).
- ❑ ❑ I received a notice stating that my prior comprehensive major medical coverage (or Medicaid) has or will terminate. **Effective date of termination:** ______________. ***(Attach copy of Notice.)*** **Reason for termination:** ______________.
  - ❑ My insurer stopped issuing coverage in New Mexico.
  - ❑ My coverage in another state's high risk pool has or will terminate due to non-residency.
  - ❑ I am moving from another state's federal Pre-existing Condition Insurance Program (PCIP). *
    - ❑ Yes ❑ No I have obtained other coverage since the termination of my previous PCIP.
  - ❑ Other (explain) ____
- ❑ ❑ I received a notice that I have, or will soon, reach the maximum allowable benefit under my current medical coverage plan. *(Attach copy of notice.)*
- ❑ ❑ I am on Medicare (Parts A & B) due to a disability, and am under the age of 65.
  Part A Effective Date___________ Part B Effective Date_________
  Note: Persons eligible under this criterion can receive the Pool's $500 Deductible Medicare Carve-Out policy only.

5.2 Eligibility under Portability Criteria (HIPAA)—State Plan Only

To be eligible under Health Insurance Portability & Accountability Act (HIPAA) criteria, you must answer yes to the first three (3) questions:

Yes No
- ❑ ❑ I have had a minimum of 18 months of continuous coverage with no single gap of more than 95 days,*
- ❑ ❑ the last of which was group coverage through an employer or trade union group health plan (may or may not include COBRA), and
- ❑ ❑ I am applying to the State Plan within 95 days of my prior coverage ending.
  DATES OF PRIOR COVERAGE:____
- ❑ ❑ **No** COBRA was available through my previous plan.*
- ❑ ❑ I was offered COBRA coverage but my insurance carrier does not serve the area where I now live.*
- ❑ ❑ I was offered COBRA coverage but I did not accept it and wish to enroll in State Plan coverage instead.
- ❑ ❑ I was offered COBRA coverage but I do not want to exhaust my COBRA benefits and wish to enroll in State Plan coverage instead.
- ❑ ❑ My group or COBRA rates are higher than the "qualifying rates" for the State Plan *(Submit proof of rates.)*
- ❑ ❑ I was offered the option of continuing coverage under COBRA, TCC (Temporary Continuation Coverage) or state continuation, and I elected and exhausted my coverage.* *Termination date:*_______________________

5.3 General Exclusions (please check yes or no for each question)

Yes No
- ❑ ❑ I am 65 or older and eligible for Medicare.
- ❑ ❑ I am eligible for Medicaid.
- ❑ ❑ I have or am eligible for an employment-related group health plan or Tricare, either as self or as a family member.
- ❑ ❑ I now have individual comprehensive health coverage. (*If you have limited coverage, you may still qualify.)*
- ❑ ❑ I voluntarily dropped Pool coverage within the last 6 months (12 months, if applying for the State Pool). My last date of coverage with the Pool was ______________.

Note: If your most recent health coverage was terminated due to non-payment of premiums or fraud, you are not eligible for the Pool.

**Please see the application checklist on the back of the application booklet for materials to include with this application.*

6. CREDIT TOWARD PRE-EXISTING LIMITATION PERIOD

If you meet one of the following criteria you may receive credit towards your pre-existing waiting period. *(Check any that apply.)*

- ❑ **6.1** I had prior health coverage before applying to the Pool and am applying for Pool coverage no later than 95 days after my prior coverage terminated. My coverage was in force for at least 6 months, and/or I met my pre-existing waiting period on my prior coverage, and may be eligible to receive credit toward the 6 month waiting period for pre-existing conditions. (*If your coverage was in force less than six months, the Pool will base your credit on the number of months you were previously insured.)*

- ❑ **6.2** My prior coverage was through Medicaid, Health Insurance Alliance (HIA), State Coverage Initiative (SCI), or another plan that did not have an exclusion for pre-existing conditions.

- ❑ **6.3** I am eligible under HIPAA (Section 5.2 on page 3) and thus have no waiting period for pre-existing conditions.

- ❑ **6.4** I am a citizen or national of the United States or legally present in the U.S., and I have had no health insurance coverage for the previous 6 months and have a pre-existing condition. (Please see the checklist at the end of this application for acceptable documentation that you are a citizen or national of the United States or are legally present in the U.S.)

You must provide documentation of prior health coverage that includes duration of coverage. You must also attach proof of termination of coverage, which you can obtain from your prior insurance company by requesting a certificate of creditable coverage.

Document requirements:

Documentation that provides proof of prior coverage includes:

- A copy of the Certificate of Creditable Coverage (obtained from previous insurance company)
- Pay stubs showing a payroll deduction for health insurance coverage
- Records from medical care providers showing health insurance coverage
- Third party statements verifying periods of coverage
- Explanations of benefits (EOBs) verifying payment to health care providers
- Correspondence from previous health plan verifying coverage
- Any other relevant documents that evidence periods of health coverage

7. PRIOR HEALTH CONDITION(S)

List all prior health conditions:	Date of diagnosis:

8. STATISTICAL & ELIGIBILITY INFORMATION

The Pool requires that you complete the following information. The program will not use income, marital or racial/ethnic status to deny eligibility, but it may use data regarding other insurance or employer-based health benefits for this purpose, based on statutory requirements. The Pool also uses this data for evaluating future insurance market reforms.

You (if you are self-employed) or your employer must complete the enclosed “Employer Verification Form” for all family members over the age of 18.

8.1. I am (check one) ❑ an employee ❑ self-employed ❑ not employed ❑ retired

If you are an employee or self-employed, what is your occupation? ______________________________

If you are employed, do you work: ❑ full-time ❑ part-time

What is the name of your employer? ______________________________

Does your employer offer health insurance to its employees? ❑ Yes ❑ No

If yes, are you currently, or have you ever been covered by your employer’s plan? ❑ Yes ❑ No

If yes, on what date did that coverage end and why? End date: __________ Reason: ______________

If your employer offers health insurance to its employees and you are not covered under your employer plan, why didn’t you take its insurance? ❑ Missed enrollment ❑ Too expensive ❑ Other ______________

8.2. Have you ever been enrolled in the Pool? ❑ Yes ❑ No

If yes, what date did your coverage begin? __________ End? __________

8.3. I am (check one) ❑ Married ❑ Single ❑ Divorced ❑ Domestic Partner ❑ Child ❑ Widowed

8.4. If you are married, is your spouse employed? ❑ Yes ❑ No

If yes, does your spouse’s employer offer health insurance to its employees? ❑ Yes ❑ No

If yes, are you currently enrolled in your spouse’s employer plan? ❑ Yes ❑ No

If no, why not? ❑ Missed enrollment ❑ Too expensive ❑ Not offered for dependents ❑ Other________

8.5. If you are under age 26, is your parent or guardian employed? ❑ Yes ❑ No

If yes, does their employer offer health insurance to its employees? ❑ Yes ❑ No

If yes, are you currently enrolled in your parent or guardian’s employer plan? ❑ Yes ❑ No

If no, why not? ❑ Missed enrollment ❑ Too expensive ❑ Not offered for dependents ❑ Other_______

8.6. In the last 6 months, have you been insured by any other insurance program (including Medicare or Medicaid)? ❑ Yes ❑ No

If yes, please answer the following:

Who is/was listed as the primary insured under the policy? ______________________________

What is the name of the insurance company? ______________________________

What is the policy number? ____________________ What is the group number? ______________

Why did the policy end?______________________________

Was the insurance Group or Individual insurance? ❑ Group ❑ Individual ❑ Do not know

If it was Group Insurance, what is the name of the employer who offered the policy? ______________

8.7. What is your racial/ethnic heritage? *We are asking for this information to help us follow federal Civil Rights laws. Title VI of the Civil Rights Act of 1964 allows us to ask this. **Answering this question is optional.***

❑ African-American ❑ Hispanic/Latino ❑ White
❑ Asian or Pacific Islander ❑ Native American/Alaskan ❑ Other

9. AFFIRMATION, UNDERSTANDING & DISCLOSURE AUTHORIZATION

I understand that I am applying to the New Mexico Medical Insurance Pool for an individual policy of medical, surgical, prescription and hospital insurance. I also understand that my coverage will become effective on the first of the month following approval and acceptance of the application to the Pool, unless I am eligible for HIPAA coverage or continuation. If eligible for continuation or HIPAA coverage, I understand that my coverage will become effective the date my prior group coverage is terminated. I will be responsible for paying premiums from my effective date forward.

I affirm that the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect until the full initial premium is paid and this application has been approved and accepted by the Pool.

Pre-existing conditions will not be covered until the Pool policy has been in effect for six months, unless the Pool waives the pre-existing condition limitation period. A pre-existing condition is a condition for which medical treatment or diagnosis has been rendered. An existing pregnancy is considered a pre-existing condition, except for HIPAA or certain other individuals who are coming off other coverage.

__________ **Applicant: initial here showing you have read & understand the above paragraph**
(parent or guardian if applicant is under 18 years of age or legally incompetent)

INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my signature on this application I authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to the New Mexico Medical Insurance Pool, or its representatives, our health information (including alcohol, chemical dependency, mental treatment, genetic testing or HIV treatment). We acknowledge and understand that this information will be used only to: 1) determine eligibility for coverage; 2) pre-authorize or process claims for benefits; 3) perform case management (including concurrent review) or quality assurance reviews or 4) conduct an audit. The Pool shall not release the medical record information it obtains to anyone else except as allowed by state and federal law. Medical record information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, the Pool may refuse to enroll me in a Pool health plan or pay future claims that I may incur if I obtain Pool insurance coverage.

I may cancel this authorization at any time by sending a written request to the Pool. My cancellation of this authorization will not affect any action the Pool took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with the Pool.

Federal law requires the Pool to tell me that if the party to whom the Pool discloses my personal information shares it with anyone else some state and federal laws may no longer protect it. Federal law prohibits redisclosure of this information without specified written authorization.

This authorization takes effect on the date I sign below and remains in effect for the lifetime of the Pool coverage or the duration of any claim, whichever is longer. For purposes of obtaining health information from a provider, a photocopy of this authorization is as valid as the original.

Signature of applicant (or parent/legal guardian/personal representative if applicant is under 18 years of age or legally incompetent):	Date
If signed by a personal representative of the applicant, please complete the following:	
Personal representative name (please print)	Relationship to applicant *(attach legal document if other than parent)*

10. AGENT INFORMATION

Insurance agents in your community are able to assist you in completing this application at no cost to you.

I certify by my signature that follows that I have explained eligibility provisions to the applicant and assure that the application is complete and accurate. I have made no statements of benefits, conditions, limitations or exclusions of the agreement except through written material furnished by the Pool. I have informed the applicant that the effective date of coverage is not guaranteed, and if approved, is determined by the New Mexico Medical Insurance Pool.

Agent signature certifies that the agent has substantially assisted with the completion of this application and has conducted a final review prior to submission to ensure that the application is complete and accurate. If the application is not complete and accurate, the Pool may choose not to pay the agent fee.

Agent Name (printed)		Tax ID Number	
Agency Name		New Mexico License Number	
Street Address	City	State	Zip
Email		Phone	Fax
Agent Signature		Date	

Checklist for Submission

Yes	No	
☐	☐	Are you ready to submit your application?
☐	☐	Is the application signed?
☐	☐	Have you filled out the application checklist on the back of this application packet?
☐	☐	Have you attached all the required documentation? (see application checklist)
☐	☐	Have you included a check for the first month's premium payable to BCBSNM? (*Premium amounts are posted on www.nmmip.org*)

Submit To:

New Mexico Medical Insurance Pool
P.O. Box 27049
Albuquerque, NM 87125-7049

APPLICATION CHECKLIST

BEFORE MAILING YOUR APPLICATION, PLEASE COMPLETE THIS CHECKLIST.

_____ I have completed every line in Section 1.
_____ I have chosen a deductible amount and given a preferred month for my insurance to start in Section 2.
_____ I have completely filled out Section 3 giving the information for all people residing at my permanent residence.
____ I have included the completed Employment (or Self-Employment) Verification form(s) for myself, my spouse and all employed family members over the age of 18 living at this address.

Section 5—Eligibility

I have included **one** of the following:

____ Letter/note from my doctor which states I have a diagnosis of one of the qualifying medical conditions listed in Section 4, containing the date of diagnosis (if qualifying under Section 4)

or

____ Letter from an insurer stating that I will be given insurance coverage comparable to that of the Pool only with a waiver/rider for a specific condition (if qualifying under Section 5.1)

or

____ Rejection from an insurance carrier for insurance coverage comparable to that offered by the Pool (if qualifying under Section 5.1)

or

____ Quote for comparable insurance from another carrier that is 125% above the Standard Risk Rate for the state of New Mexico (if qualifying under Section 5.1)

or

____ Notice stating that my prior comprehensive major medical coverage (or Medicaid) has or will terminate giving the date of termination (if qualifying under Section 5.1)

or

____ Notice that I have, or will soon, reach the maximum allowable benefit under my current medical coverage plan which includes the estimated date the coverage will end (if qualifying under Section 5.1)

or

____ (If under 65) Copy of Medicare card stating when parts A and B became effective (if qualifying under section 5.1)

or

____ Statement or CoCC from another state's PCIP that you were covered under that program until you moved to New Mexico permanently. Note: When transferring from another state's PCIP, the above document serves as proof of citizenship/legal residency and proof of a pre-existing condition.

Proof of Citizenship/Residency

____ Proof of New Mexico Residency
- ____ New Mexico State Income Tax Return marked "resident"
- ____ Valid New Mexico Driver's License
- ____ Lease agreement in my name
- ____ Utility bill in my name at my address

____ Proof of Citizenship or Naturalization (if applying for Federal High Risk Pool)
- ____ Birth Certificate
- ____ Naturalization/Citizenship Papers
- ____ Passport
- ____ Document confirming status as a noncitizen national

____ Proof of legal residency in the US (if applying for Federal High Risk Pool)
- ____ I-327 (Reentry permit)
- ____ I-551 (Permanent Resident Card)
- ____ I-94 with Unexpired Foreign Passport
- ____ I-571 (Refugee Travel Document)
- ____ I-766 (Emp. Auth. Doc.)
- ____ Other document with I-94 or Alien Number
- ____ Machine Readable Immigrant Visa (with temporary I-155 Language) affixed to Unexpired Foreign Passport
- ____ Temp I-551 Stamp affixed to I-94 or Unexpired Foreign Passport
- ____ Unexpired Foreign Passport for Visa Waiver Program travelers
- ____ I-20 (Certificate of Eligibility for Non-immigrant (F-1) Student Status) with I-94 and Unexpired Foreign Passport
- ____ DS2019 (Certificate of Eligibility for Exchange (J-1) Visitor Status) with I-94 and Unexpired Foreign Passport

Proof of Prior Coverage

(Note: if qualifying HIPPA, please ensure that there is proof of 18 months of coverage)

____ Certificate of Creditable Coverage from prior insurance carrier (group or individual, COBRA, Medicaid, SCI, etc.)
____ Statement from prior insurance carrier that they will not cover members in the State of New Mexico
____ Pay stubs showing a payroll deduction for health insurance coverage
____ Records from medical care providers showing health insurance coverage
____ Third party statements verifying periods of coverage
____ Explanations of Benefits (EOBs) verifying payment to health care providers
____ Correspondence from previous health plan verifying coverage
____ Any other relevant documents that evidence periods of health coverage