Application for Coverage Medicare Carve-Out

1. APPLICANT INFORMATION

Last Name



Birth Date (MM/DD/YYYY)

To be eligible for the Medicare Carve-Out plan, you must be under age 65 and be enrolled in Medicare Parts A <u>and</u> B due to disability.

PO Box 780548 San Antonio, Tx 78278 1-866-306-1882 Fax 210-239-8449 www.nmmip.org

Social Security Number

NOTE: Every person applying for a New Mexico Medical Insurance Pool policy, even if in the same family, must complete a separate application.

First Name

If you have questions or need assistance completing this application please contact 1866-306-1882 or email NMMIP_Eligibility@90degreebenefits.com.

idence Add	ress (Phys	sical address required)			City	[State	Zip
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ailing Address	5				City				County
ling Address	(if differen	t than mailing)			City			State	County
mail Address	(optional)		Gender M	□ F	Home Phone	С	ell Phone	Work Pho	one
am a resid	dent of t	he state of New Mexic	0.		1	☐ Ye	s 🗖 No		
understan	d the fir	st month's premium mi	ust be included v	with the app	lication.				
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urrent Medical Conditions (Optional):							
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	paid and this application	he best of my knowledge and belief. I understand that no coverage will be has been approved by the Pool Administrator. I understand that if I obtain or strator of the other coverage.					
Signature of Applicant	Date	Signature of Parent or Legal Guardian (if applicant is under 18 or legally incompetent)					
		Relationship to Applicant					
		For Broker/Agency Use Only					
Make Check payable to: New Mexico Medical Insurance Pool (NMMIP)	If application is completed with agent/state agency assistance, complete t following: (Please Print) Agent's Name					
Mail complete application and prem	ium check to:	Company Name					
New Mexico Medical Insurance Pool P.O. Box 780548 San Antonio,Tx 78278		Mailing Address City State Zip					
If sending via FedEx, mail to:		TIN/SSN#					
P.O. Box 780548 San Antonio,Tx 78278							

Date