



New Mexico Medical Insurance Pool Termination Request

Note: Insurance agents are available to assist you at no cost.

Please cancel my coverage with the New Mexico Medical Insurance Pool effective _____
mm/dd/yyyy

Reason (provide proof):

Effective Date (mm/dd/yyyy):

- Obtained coverage through the Exchange
- Obtained coverage through Centennial Care
- Obtained coverage through the Commercial Market
- Qualified for Medicare
- Moved out of State
- Other (Please specify) _____

Signature

Date

Printed name

Policy # M725 _ _ _ _

Address

City, State, Zip

Telephone #

By my signature above, I certify that I have received assistance from the following agent:

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

Agent signature certifies that the agent has substantially assisted the individual listed above with acquisition of other health insurance coverage. If it is determined that the agent did not assist the above named individual, the Pool may choose not to pay the agent fee.

Mail:
 New Mexico Medical Insurance
 Pool P.O. Box 780548
 San Antonio, TX 78278
 or
 Fax: 210-239-8449