new mexico health connections

EMPLOYEE ENROLLMENT/CHANGE FORM

Employer Name:	Department/Location:	New Enrollee: ☐ Effective Date: ____/____/ ____
Date of Hire/Reinstated: ___/___/____	COBRA Yes ☐ No ☐ Variable Hour Employee? Yes ☐ No ☐	Hours Worked Per Week: / Enrollment Changes: ☐ Subscriber ID# _____

Are you waiving your employer's group coverage? Yes, ☐ I hereby waive New Mexico Health Connections medical coverage. Complete Step 2 below, then sign and date form.
Reason for Waiver: Individual exchange plan ☐ Individual off-exchange plan ☐ Another Employer Group Plan ☐ Medicare/Medicaid ☐ Other Coverage ☐ Not Covered ☐

STEP 1: ENROLLMENT EVENTS/CHANGES

Open Enrollment? No ☐ Yes ☐ (if Yes, then skip to Step 2) Special Enrollment Event? No ☐ Yes ☐, date: ___/___/___
Adding a Dependent? No ☐ Yes ☐ Marriage ☐ Birth, Adoption, Placement for Adoption or Foster Care ☐ Court Order ☐ Loss of other coverage ☐ Other: _____

Termination of policy ☐ OR Termination of dependent ☐ Name:_____ Termination Date:____/____/_____ Reason: Terminated ☐ Divorce ☐ Death ☐ Other: _____

STEP 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security Number (SSN):		DOB: ___/ ____/ ____
Home Address:		Apt./Ste:	City:	State:	ZIP:
Mailing Address (if different then above):		Apt./Ste:	City:	State:	ZIP:
Primary Phone: ( )	Other Phone: ( )		E-mail Address:		Gender/Sex: M ☐ F ☐

Ethnicity/Race: American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black or African American ☐ Hispanic ☐ White ☐ Multiracial ☐

Do you or any of your dependents prefer a spoken or written language other than English? Yes ☐ No ☐ If yes, please list here:	Do you or any of your dependents require assistance due to a disability? Yes ☐ No ☐ If yes, please describe:

STEP 3: PLAN INFORMATION

Your selection will be limited to the benefit plans made available to you by your employer. Any benefit discrepancies will default to the benefit plan offering selected by your employer. Please review the information in your enrollment materials or check with your benefits coordinator if you are uncertain about the types of benefit plans available to you. Your coverage election will be the health benefit selection made by your employer.

If your employer offers multiple NMHC plans, select your coverage: HMO ☐ or PPO ☐ Plan Name: _____	Coverage applied for: Employee only ☐ 2-Party ☐ Employee + Child(ren) ☐ Family ☐

STEP 4: DEPENDENT INFORMATION

	Last Name	First Name	M.I.	SSN	Date of Birth	Gender/Sex
Legal Spouse/Domestic Partner						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐

Will you or any other family member listed above continue to be covered by any other insurance company? Yes ☐ No ☐		Insurance Company:	List name(s):
Do you or any family member listed above have Medicare? Yes ☐ No ☐	Part A ☐ Part B ☐	Member Name:	Medicare Number:

STEP 5: SIGN AND DATE

READ PAGE 2 OF THIS APPLICATION. By signing this application, I attest that I have read both sides of this application and warrant my current and continuing authority to act on behalf of and fully bind all of the above Dependents with respect to every provision of the NMHC Evidence of Coverage. If you have questions, please call our Help Center at 1-855-7MY-NMHC (855-769-6642), Monday through Friday from 8 a.m. to 5p.m.

Employee Signature	Date	Employer Signature	Date

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.

STEP 6: IMPORTANT – PLEASE READ CAREFULLY

RELEASE OF CONFIDENTIAL HEALTH INFORMATION

By signing this application, I CONSENT, to the extent permitted by applicable law, to the release of or use of Confidential Health Information (as defined below) by any person or entity including, without limitation, practitioners, pharmacies or pharmacy benefit managers, providers, and insurance companies to NMHC or its designees for any permitted purpose, including but not limited to insurance eligibility, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment or healthcare operations activities of NMHC. It is understood that it may be necessary for the parties administering the plan in which I/we are enrolling to obtain and/or provide to others this Confidential Health Information.

I understand that authorizing the disclosure of this Confidential Health Information is voluntary, and signing this authorization can be refused; however, if not signed, the processing of this Application may be delayed or inhibited.

I understand that a full description of NMHC's privacy and confidentiality policy related to Confidential (Also known as Protected) Health Information is available on our website at www.mynmhc.org or by calling NMHC Customer Care at 1-855-769-6642.

I understand my consent, here, does not permit use of Confidential Health Information when an authorization is required by law.

I understand that this authorization is in effect for twenty-four (24) months from the date of this application or until written notice is sent to NMHC to revoke it.

I understand that I may revoke this authorization by writing to: New Mexico Health Connections, HIPAA Privacy Officer, P.O. Box 36719, Albuquerque, NM 87176.

"Confidential Health Information" includes, with respect to me and/or a covered dependent/minor child, any individually identifiable health information, including but not limited to medical, dental, mental health, substance abuse, communicable disease, Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) related information, as well as any disability or employment related information.

AUTHORITY TO ACT

I hereby represent my current and continuing authority to act on behalf of myself and/or my legal dependent child(ren) with respect to every provision of the Agreement. All information on this Application is correct and true. I know that my information on this form will only be used to enroll myself and my eligible dependents for health coverage and will be kept private as required by law. I understand that upon completion of my enrollment I will receive an NMHC Evidence of Coverage and Summary of Benefits and Coverage, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

ACCURACY OF INFORMATION PROVIDED ON THIS APPLICATION

I agree that I have read and understood all questions included on this application. By signing below, I certify that the answers provided are correct, complete and wholly true to the best of my knowledge and belief.

NOTIFICATION OF CHANGES

I know that I must tell NMHC or my Employer if anything changes (and is different than) what I wrote on this application. I can visit www.mynmhc.org or call 1-855-7MY-NMHC to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

COVERED BENEFITS

I understand that covered benefits, utilization management procedures, and plan exclusions and limitations are subject to the plan's Evidence of Coverage (EOC) and/or Summary of Benefits and Coverage (SBC). These documents are available at www.mynmhc.org/shop-plans-on-exchange.aspx. I also may contact NMHC at 1-855-7MY-NMHC, Monday through Friday, 8:00 a.m. to 5:00 p.m., to request a printed copy of these documents.

COPY OF APPLICATION

I understand that I am entitled to a copy of this signed Application and may contact NMHC to obtain a copy. Premium, price or charge differentials because of location or age based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability.