



EMPLOYEE ENROLLMENT/CHANGE FORM

Employer Name: _____		Department/Location: _____	New Enrollee: <input type="checkbox"/> Effective Date: ___/___/___
Date of Hire/Reinstated: ___/___/___	COBRA Yes <input type="checkbox"/> No <input type="checkbox"/> Variable Hour Employee? Yes <input type="checkbox"/> No <input type="checkbox"/>	Hours Worked Per Week: _____	Enrollment Changes: <input type="checkbox"/> 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 <input type="checkbox"/> F <input type="checkbox"/>
Ethnicity/Race: American Indian/Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Multiracial <input type="checkbox"/>				
Do you or any of your dependents prefer a spoken or written language other than English? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list here: _____			Do you or any of your dependents require assistance due to a disability? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> or PPO <input type="checkbox"/> Plan Name: _____	Coverage applied for: Employee only <input type="checkbox"/> 2-Party <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/>
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STEP 4: DEPENDENT INFORMATION

	Last Name	First Name	M.I.	SSN	Date of Birth	Gender/Sex
Legal Spouse/Domestic Partner						M <input type="checkbox"/> F <input type="checkbox"/>
Child						M <input type="checkbox"/> F <input type="checkbox"/>
Child						M <input type="checkbox"/> F <input type="checkbox"/>
Child						M <input type="checkbox"/> F <input type="checkbox"/>

Will you or any other family member listed above continue to be covered by any other insurance company? Yes <input type="checkbox"/> No <input type="checkbox"/>	Insurance Company: _____	List name(s): _____
Do you or any family member listed above have Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>	Part A <input type="checkbox"/> Part B <input type="checkbox"/>	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 _____
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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.