

## APPLICATION FOR HEALTH COVERAGE – INDIVIDUAL PLAN

Contact us online: [www.mynmhc.org/Contact\\_Us.aspx](http://www.mynmhc.org/Contact_Us.aspx) or by phone at 1-844-391-0715.

Apply for coverage online: [www.mynmhc.org](http://www.mynmhc.org) or fax to 1-888-523-0043, or submit by mail to the address above.

**To avoid potential delays, please print legibly.**

COVERAGE INFORMATION	
Application Type:	<input type="checkbox"/> New Coverage <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment*
Requested Effective Date (required):	____/____/____ (MM/DD/YYYY) Coverage will be effective on the first day of the month following receipt of this completed Application, provided that this completed Application is received by NMHC by the 15th of the previous month, unless a later effective date is requested.

\*Proof of eligibility for special enrollment will be required. Information on eligibility for special enrollment periods is available at [www.mynmhc.org](http://www.mynmhc.org).

PRIMARY INSURED INFORMATION			
Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page. <b>For child-only coverage, please list the youngest child as the Primary Applicant.</b>			
First Name:	Middle Initial:	Last Name:	
Social Security Number:	Date of Birth:	Current Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Physical Address:		City:	
County:	State:	Zip:	
Mailing Address (if different):		City:	
County:	State:	Zip:	
Primary Phone:	Alternate Phone:	Email:	
Preferred spoken language if other than English:		Tobacco Product* Use (past 12 months)? <input type="checkbox"/> Y <input type="checkbox"/> N	
Ethnicity (optional): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Multiracial			

\*As stated in Section 201(rr) of the Federal Food, Drug, and Cosmetic Act in relevant part, a Tobacco Product means any product made or derived from tobacco that is intended for human consumption, including, among others, e-cigarettes, gels, e-vapor, dissolvables, pipe tobacco, hookah tobacco, cigars, and novel and future tobacco products.

DEPENDENT INFORMATION						
Complete ONLY if your spouse/partner and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. Social Security Numbers (or document numbers for any legal immigrants) are <b>required</b> for anyone applying for health insurance. *Proof of eligibility for Court-Ordered Dependents will be required.						
Name (First, MI, Last)	Gender	Social Security Number	Relationship to Applicant	Disabled?	Tobacco Product* Use (past 12 months)?	Birth Date (MM/DD/YY)
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> SPOUSE/PARTNER	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> COURT ORDER	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> COURT ORDER	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> COURT ORDER	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> COURT ORDER	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Are all applicants U.S. citizens or U.S. nationals?		<input type="checkbox"/> Y <input type="checkbox"/> N* Applicant Name: _____ *If No, proof of eligible immigration status for applicant is required. Immigration document type: _____ Document ID number: _____				
Will you or any applicants listed have other medical coverage in addition to this plan? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, name: _____ Type of coverage: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Coverage <input type="checkbox"/> <input type="checkbox"/> Employer Group Coverage <input type="checkbox"/> Other: _____						



Primary Applicant Name: \_\_\_\_\_

**TERMS AND CONDITIONS**

By signing this application, it is consented by all applicants, to the extent permitted by applicable law, to the release of or use of Protected Health Information (PHI)\* (as defined below) by any person or entity including, without limitation, practitioners, pharmacies or pharmacy benefit managers, providers, health information exchanges, 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 PHI. Therefore:

1. It is authorized that any person or entity having PHI to provide any such PHI upon request to NMHC and its participating providers, or any entity performing a service for the purpose of eligibility determination under the plan, the administration of the plan, the performance of any NMHC program or operation or assessing of healthcare services and supplies.
2. It is authorized for NMHC to disclose any PHI to any person, company, or entity when it determines that such disclosure is necessary or appropriate for the administration of the Plan, the performance of NMHC programs or operations, assessing quality and accessibility of healthcare services and supplies, or reporting to third parties involved in plan administration.
3. I know that I must tell NMHC if anything changes (and is different than) what I wrote on this application. I can visit [www.mynmhc.org](http://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.

\*Protected 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.

**By completing this form:**

- I understand that I represent my current and continuing authority to act on behalf of myself and all dependent(s) listed on this form.
- I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.
- I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.
- I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application. I acknowledge that no one applying for coverage on this application is incarcerated (detained or jailed).
- **ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRADULENT 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.**
- At any time when New Mexico Health Connections is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy due to an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application, New Mexico Health Connections may at its option make an offer to reform the policy already in force and/or change the rating category/level.
- I understand this Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting New Mexico Health Connections. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.
- I understand that I may request a copy of this Application by contacting New Mexico Health Connections at 1-855-7MY-NMHC. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.
- 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](http://www.mynmhc.org/shop-plans-on-exchange.aspx). I also may contact New Mexico Health Connections 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.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans  
Required

Date Signed

Printed Name

**AGENT/PRODUCER INFORMATION**

Name:	Agent ID (NPN):
Agency Name:	Phone: