

Member Change Form

Individual & Family Plan

CONTACT US

- Online: www.mynmhc.org
- Phone: Call Individual Sales, 1-844-391-0715, Monday through Friday, 8:00 a.m. to 5:00 p.m.

SUBMIT TO:

- Fax: 1-888-523-0043
- Mail: New Mexico Health Connections, P.O. Box 36719, Albuquerque, NM 87176
- Email: enroll@mynmhc.org
- **To avoid any processing delays, please print legibly.**

PRIMARY INSURED INFORMATION

Last Name:		First Name:	
Social Security Number:		Member ID Number:	
Mailing Address:		City:	State:
Phone Number:		Email:	

PLAN SELECTION – For Open Enrollment Only

Requested Effective date of Coverage: ____/____/____ (MM/DD/YYYY)
All family members listed under your coverage will be enrolled on the same plan.

Care Connect Gold HMO	<input type="checkbox"/> Gold Plus	<input type="checkbox"/> Gold Essential
Care Connect Silver HMO	<input type="checkbox"/> Silver Plus	<input type="checkbox"/> Silver HDHP
Care Connect Bronze HMO	<input type="checkbox"/> Bronze Plus	<input type="checkbox"/> Bronze HDHP
Catastrophic Plan HMO	<input type="checkbox"/> Only for individuals under 30 years of age, or a person 30 years of age or over holding a Certificate of Exemption.	

ADDRESS CHANGE

Physical Address Mailing Address

Address: _____

City: _____ State: _____ Zip: _____ County: _____

FAMILY STATUS CHANGE

Cancel Dependent Add Dependent

Marriage Divorce Newborn/Adoption Other: _____ Date of Event: ____/____/____

Name of Dependent to Add or Cancel	Date of Birth	Social Security Number	Gender	Primary Care Physician
			<input type="checkbox"/> M / <input type="checkbox"/> F	
			<input type="checkbox"/> M / <input type="checkbox"/> F	

CANCEL COVERAGE

Coverage will be canceled for all members on the policy. Please select reason below:

Other Insurance Date of Coverage: _____ Other: _____ Date of Event: _____

PREMIUM

For premium payment changes, visit www.mynmhc.org and select *Pay My Bill*; or call Customer Care at 1-855-7MY-NMHC (1-855-769-6642).

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 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 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.**
- 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/individual-plan-documents.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

Date Signed

Printed Name

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-769-6642 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-769-6642 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, koji' hódíílnih 1-855-769-6642 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-769-6642 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-769-6642 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-769-6642 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-769-6642 (رقم هاتف الصم والبكم: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-769-6642 (TTY: 711) 번으로 전화해 주십시오.
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-769-6642 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-769-6642 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-769-6642 (ATS : 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-769-6642 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-769-6642 (телетайп: 711).
Hindi	सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं नि:शुल्क, आपके लिए उपलब्ध हैं। 1-855-769-6642 पर कॉल करें (टीटीवी: 711)।
Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-769-6642 تماس بگیرید. (TTY: 711)
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-769-6642 (TTY: 711).

Notice of Non-Discrimination and Accessibility

Aviso de no discriminación y accesibilidad

The following is a statement describing nondiscrimination for NMHC and the services it provides to its clients and members.

- We do not discriminate on the basis of race, color, national origin, age, disability, or gender in our health programs or activities.
- We provide help free of charge to people with disabilities or whose primary language is not English. To ask for a document in another format such as large print, or to get language help such as a qualified interpreter, please call NMHC Customer Service at 1-855-769-6642, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY: 1-800-659-8331.
- If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can send a complaint to: NMHC Compliance Hotline, 2440 Louisiana Blvd. NE, Suite 601, Albuquerque, NM 87110. Phone: 1-855-882-3904. Fax: 1-866-231-1344.

You also have the right to file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone, or by mail:

- Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- Phone: Toll-free: 1-800-368-1019, TDD: 1-800-537-7697
- Mail: U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

Aviso de no discriminación y accesibilidad

A continuación presentamos una declaración que resume la norma de no discriminación de NMHC y los servicios que prestamos a nuestros clientes y asegurados.

- No discriminamos por la raza, el color, el origen nacional, la edad, las discapacidades o el sexo en nuestras actividades o programas de salud.
- Ayudamos gratuitamente a las personas que tienen discapacidades o cuyo idioma nativo no es el inglés. Para pedir un documento en otro formato, como en letra grande, o para recibir la ayuda de un intérprete calificado, favor de llamar al Centro de Atención al Cliente de NMHC al 1-855-769-6642, para los servicios TTY llame al 1-800-659-8331, de lunes a viernes, de las 8:00 de la mañana a las 5:00 de la tarde.
- Si usted cree que no hemos prestado estos servicios o que le hemos discriminado de alguna otra manera por su raza, color, origen nacional, edad, discapacidad o sexo, puede enviar una queja a: NMHC Compliance Hotline, 2440 Louisiana Blvd. NE, Suite 601, Albuquerque, NM 87110. Teléfono: 1-855-882-3904. Fax: 1-866-231-1344.

Además tiene derecho a presentar una queja directamente al Departamento de Salud y Servicios Humanos de los EE. UU. [U.S. Dept. of Health and Human Services] ya sea en línea, por teléfono o por correo:

- En línea: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Los formularios de queja están a su disposición en: <http://www.hhs.gov/ocr/office/file/index.html>.
- Por teléfono: Línea telefónica gratis: 1-800-368-1019, TDD: 1-800-537-7697
- Por correo: U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201