

# Application for Coverage



NOTE: Every person applying for a New Mexico Medical Insurance Pool policy, even if in the same family, must complete a separate application. Please read the eligibility requirements section in the Pool brochure.

If you need assistance completing this application, call (505) 424-7105 or toll free (866) 622-4711.

P.O. Box 27049  
 Albuquerque, NM 87125-7049  
 1-800-432-0750  
 Fax: (505) 816-5671  
 www.nmmip.org  
 Email: info@nmmip.org

(Please print in ink.)

|                                                                                                                                                                                                                            |                   |             |                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------|------------------|
| Name (Last, First, Middle Initial)                                                                                                                                                                                         |                   |             | Social Security# |
| Sex (M or F)                                                                                                                                                                                                               | Birth Date<br>/ / | Home Phone# | Work Phone#      |
| Street or Physical Address (Required)                                                                                                                                                                                      |                   |             |                  |
| Mailing Address (If different from above)                                                                                                                                                                                  |                   |             |                  |
| City                                                                                                                                                                                                                       |                   | State<br>NM | Zip Code         |
| Deductible Option: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000<br><input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 |                   |             |                  |
| <b>I understand the first month's premium must be included with the application.</b>                                                                                                                                       |                   |             |                  |

| FOR OFFICIAL USE ONLY                                                            |                              |
|----------------------------------------------------------------------------------|------------------------------|
| Effective Date _____                                                             | Waiver Status _____          |
| UIN      8 7 6 9 1 _____                                                         |                              |
| Ck # _____                                                                       | Amt \$ _____                 |
| Group # _____                                                                    | Contract Code      41A _____ |
| Age _____                                                                        | Premium \$ _____             |
| Age _____                                                                        | Premium \$ _____             |
| LIPP % _____                                                                     | LIPP Premium \$ _____        |
| Auto Pay Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |
| CoCC Required? <input type="checkbox"/> Yes <input type="checkbox"/> No          | Received Date: _____         |

- Are you a New Mexico resident?     Yes     No  
 You must reside in New Mexico and have a permanent street or physical address.
- Please indicate which of the following reasons apply and attach a copy of the qualifying notice.
  - Notice of rejection for comprehensive major medical coverage.
  - Note or letter from a physician stating that you have been specifically diagnosed with the following medical or health conditions(s):

- |                                                                   |                                                                                          |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> AIDS                                     | <input type="checkbox"/> Malignant Tumor (If treated/occurred within previous 4 yrs.)    |
| <input type="checkbox"/> Alcohol/Drug Abuse                       | <input type="checkbox"/> Metastatic Cancer                                               |
| <input type="checkbox"/> ALS (Lou Gehrig's Disease)               | <input type="checkbox"/> Motor or Sensory Aphasia                                        |
| <input type="checkbox"/> Angina Pectoris                          | <input type="checkbox"/> Muscular Atrophy or Dystrophy                                   |
| <input type="checkbox"/> Arteriosclerosis Obliterans              | <input type="checkbox"/> Myasthenia Gravis                                               |
| <input type="checkbox"/> Artificial Heart Valve                   | <input type="checkbox"/> Myotonia                                                        |
| <input type="checkbox"/> Ascites                                  | <input type="checkbox"/> Open Heart Surgery                                              |
| <input type="checkbox"/> Cardiomyopathy                           | <input type="checkbox"/> Paraplegia or Quadriplegia                                      |
| <input type="checkbox"/> Cirrhosis of the Liver                   | <input type="checkbox"/> Parkinson's Disease                                             |
| <input type="checkbox"/> Coronary Insufficiency                   | <input type="checkbox"/> Peripheral Arteriosclerosis (If treated within previous 3 yrs.) |
| <input type="checkbox"/> Coronary Occlusion                       | <input type="checkbox"/> Polyarteritis (Periarteritis Nodosa)                            |
| <input type="checkbox"/> Crohn's Disease                          | <input type="checkbox"/> Polycystic Kidney                                               |
| <input type="checkbox"/> Cystic Fibrosis                          | <input type="checkbox"/> Posterolateral Sclerosis                                        |
| <input type="checkbox"/> Dermatomyositis                          | <input type="checkbox"/> Psychotic Disorders                                             |
| <input type="checkbox"/> Diabetes (Insulin Dependent)             | <input type="checkbox"/> Sickle Cell Anemia                                              |
| <input type="checkbox"/> Friedrich's Disease                      | <input type="checkbox"/> Silicosis                                                       |
| <input type="checkbox"/> Hemophilia                               | <input type="checkbox"/> Splenic Anemia (True Banti's Syndrome)                          |
| <input type="checkbox"/> Hepatitis C (Active)                     | <input type="checkbox"/> Still's Disease                                                 |
| <input type="checkbox"/> HIV+                                     | <input type="checkbox"/> Stroke (CVA)                                                    |
| <input type="checkbox"/> Hodgkin's Disease                        | <input type="checkbox"/> Syringomyelia                                                   |
| <input type="checkbox"/> Huntington's Chorea                      | <input type="checkbox"/> Tabes Dorsalis (Locomotor Ataxia)                               |
| <input type="checkbox"/> Hydrocephalus                            | <input type="checkbox"/> Thalassaemia (Cooley's or Mediterranean Anemia)                 |
| <input type="checkbox"/> Intermittent Claudication                | <input type="checkbox"/> Topectomy and Lobotomy                                          |
| <input type="checkbox"/> Juvenile Diabetes                        | <input type="checkbox"/> Wilson's Disease                                                |
| <input type="checkbox"/> Kidney Failure                           |                                                                                          |
| <input type="checkbox"/> Lead Poisoning with Cerebral Involvement |                                                                                          |
| <input type="checkbox"/> Leukemia                                 |                                                                                          |
| <input type="checkbox"/> Lupus Erythematosus Disseminate          |                                                                                          |

- Notice of health insurance being available ONLY with a rider, waiver, or restrictive provision.
- Notice that your premium rate for in-force or applied-for health insurance coverage that exceeds the qualifying rate for the Pool. Compare with the deductible plan closest to your plan without going over the applicant's age and sex.
- Coverage through the New Mexico Health Insurance Alliance (NMHIA).
- Notice stating that your prior medical coverage has, or will terminate.

The effective date of termination is \_\_\_\_\_  
 State reason for termination \_\_\_\_\_  
 \_\_\_\_\_

- Notice stating that you are on Medicare due to a disability and under the age of 65, (attach a copy of your Medicare card). Note: Persons eligible due to this criteria will receive the Pool Medicare Carve-Out policy.
- A COBRA plan that is terminating or has a rate higher than the Pool's qualifying rate. NOTE: YOU MUST COMPLETE THE HIPAA ELIGIBILITY FORM.

- To help determine the value of this program for those people it covers, please state the primary health condition or conditions preventing you from obtaining standard coverage. This information will be confidential. Conditions:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Continue on back

4. As of the date that this application is signed, are you eligible for and/or covered by Medicare, Medicaid, or any other health insurance benefit plan through an employer, individual plan, or as a dependent?

Yes  No

If yes, name of coverage/company:

\_\_\_\_\_

If you are eligible but not covered under this program, why not? \_\_\_\_\_

Have you ever been covered by the Pool program before?

Yes  No

Reason for termination: \_\_\_\_\_

\_\_\_\_\_

I certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until the full initial premium is paid and this application has been approved by the Pool Administrator. I understand that if I obtain or become eligible for health coverage, I will notify the Pool Administrator of the other coverage.

I understand that unless I am provided with written notice of a waiver, no benefits are available for six months after the effective date of the Policy for pre-existing conditions. A pre-existing condition is a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant within six months before the effective date of coverage.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian,  
if applicant is under 18 or legally incompetent

\_\_\_\_\_  
Date

## COMPLETE APPLICATION

IF APPLICATION IS COMPLETED WITH AGENT/STATE AGENCY ASSISTANCE, COMPLETE THE FOLLOWING:  
(Please Print)

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Agents Name

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
TIN/SSN#

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Have you:**

- answered all questions completely?
- attached all notices?
- signed and dated application?
- included a check for the first month's premium?

**Make check payable to BCBSNM**

**Please mail complete application to:**

New Mexico Medical Insurance Pool  
P.O. Box 27049  
Albuquerque, NM 87125-7049

Delivery Address:  
5701 Balloon Fiesta Parkway  
Albuquerque, NM 87113

**Coverage will begin the first day of the month following the receipt and approval of your application**