Application for Coverage
Medicare Carve-Out

P.O. Box 1090
Great Bend, KS 67530
1-844-728-7896
TTY 1-844-728-7897
www.nmmip.org

To be eligible for the Medicare Carve-Out plan, you must be under age 65 and be enrolled in Medicare Parts A and B due to disability.

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

If you have questions or need assistance completing this application, please contact 1-844-728-7896, TTY 1-844-728-7897 or email info@nmmip.org

1. APPLICANT INFORMATION

Last Name	First Name	MI	Age	Birth Date (MM/DD/YYYY)	Social Security Number
				/ /	- -

Residence Address (Physical address required)	City	State	Zip
		NM	
Mailing Address	City		County
Billing Address (if different than mailing)	City	State	County

Email Address (optional)	Gender	Home Phone	Cell Phone	Work Phone
	☐ M ☐ F			

I am a resident of the state of New Mexico. ☐ Yes ☐ No

I understand the first month's premium must be included with the application.

2. Qualifying Conditions

Please answer every question

Yes	No	
☐	☐	I am under 65 years of age and enrolled in Medicare due to a disability.
☐	☐	I have Medicare **(copy of your award letter or Medicare Card is required with this application).**

Part A Effective Date: ______________________

Part B Effective Date: ______________________

☐	☐	I have other insurance (other than Medicare).

If "yes", with what insurance company?______________________________
When does coverage end?_________________________ Why is coverage ending?____

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☐ ☐ I have been covered by the Pool in the past. Dates of coverage: from__________to__________
Reason for termination:____

Current Medical Conditions (Optional):

1.______________________________________ 3.______________________________________

2.______________________________________ 4.______________________________________

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.

______________________	__________	______________________	__________
Signature of Applicant	Date	Signature of Parent or Legal Guardian (if applicant is under 18 or legally incompetent)	Date

____
Relationship to Applicant

Make Check payable to:
New Mexico Medical Insurance Pool (NMMIP)

Mail complete application and premium check to:

New Mexico Medical Insurance Pool
P.O. Box 1090
Great Bend, KS 67530

If sending via FedEx, mail to:
Benefit Management, LLC
2015 16th Street
Great Bend, KS 67530

For Broker/Agency Use Only		
If application is completed with agent/state agency assistance, complete the following: (Please Print)		
Agent's Name		
Company Name		
Mailing Address		
City	State	Zip
TIN/SSN#		
Phone #		
Signature		
Date		