Application for Coverage
Medicare Carve-Out

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 and Medicare Part D for prescription coverage.

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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Age</th>
<th>Birth Date (MM/DD/YYYY)</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residence Address (Physical address required)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing Address (if different than mailing)</th>
<th>City</th>
<th>State</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email Address (optional)</th>
<th>Gender</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

☐ Yes  ☐ No  I have Medicare (copy of your award letter or Medicare Card is required with this application).

Part A Effective Date: ________________________

Part B Effective Date: ________________________

Part D Effective Date: ________________________

Rev 01/01/2019
☐ ☐ I have other insurance (other than Medicare).
If “yes”, with what insurance company? ____________________________
When does coverage end? ____________________________
Why is coverage ending? ____________________________

☐ ☐ I have been covered by the Pool in the past. Dates of coverage:
from ______ to ______
Reason for termination: ____________________________

Current Medical Conditions (Optional):
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
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 __________________ 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 ____________