



NEW MEXICO HEALTH INSURANCE ALLIANCE

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 1-800-204-4700 • 505-989-1600
 Fax: 505-988-3461
 Website: www.nmhia.com

Employee Form

Please check one
 Enrollment Waiver

REQUESTED EFFECTIVE DATE: _____

Approved Effective Date: _____

| SECTION A: Employee Information | | | | | | ***PLEASE PRINT CLEARLY & COMPLETE ALL INFORMATION*** | | | | | |
|--|--|---|-------------------|--|---------------|---|--------------|-----------|--|-----|--|
| Employer/Company Name | | | | Date of Hire | | Hrs worked per week | | Job Title | | | |
| Employee Name (Last, First Middle Initial) | | | Social Security # | | Date of Birth | | Sex (M or F) | | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | | |
| Home Mailing Address | | | | City | | County | | State | | Zip | |
| Home Phone Number | | Work Phone Number | | Tier: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & 1 child <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family | | | | | | | |
| Physician Name (HMO plan only) | | Type of Coverage: <input type="checkbox"/> New group enrollment <input type="checkbox"/> New employee in existing group <input type="checkbox"/> Waiver period employee <input type="checkbox"/> COBRA/State Continuation – Effective date: _____ End Date: _____ <input type="checkbox"/> None: Go to Waiver of Coverage below | | | | | | | | | |

| SECTION B: Coordination of Benefits (please answer all questions) | |
|---|--|
| 1. Are you or any dependents covered under another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, who? _____ | Carrier: _____ Effective Date: _____ |
| 2. Are you or any dependents applying for coverage under another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, who? _____ | Carrier: _____ Effective Date: _____ |
| 3. Are you or any of your dependents eligible or covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If "Yes," who?: _____ | Beneficiary: _____ Effective Date: _____ |

| SECTION C: Dependents to be Covered | | | | | | ***PLEASE PRINT CLEARLY & COMPLETE ALL INFORMATION*** | | | | | |
|-------------------------------------|--|----------|-------------------|--|---------------|---|-----|--------------------------------|--|--|--|
| | | Relation | Social Security # | | Date of Birth | | M/F | Physician Name (HMO plan only) | | | |
| Legal Spouse Name | | | | | | | | | | | |
| Dependent Name | | | | | | | | | | | |
| Dependent Name | | | | | | | | | | | |
| Dependent Name | | | | | | | | | | | |

| SECTION D: 6 Months Prior Coverage – Only Required for PPO plans - Applies to employees and dependents over age 19. Please list information for self and dependents below. | | | | | | | |
|--|---------------------------|--|---------------------------|---------------------|---------------------|----------------|------------------|
| Name | Company Name/Phone Number | | Carrier Name/Phone Number | Policy Number (SSN) | Group or Individual | Effective Date | Termination Date |
| | | | | | | | |
| | | | | | | | |

| SECTION E: Waiver of Coverage - ONLY FILL OUT IF YOU DO NOT WANT THE COVERAGE | |
|--|-----------------------------------|
| <input type="checkbox"/> I certify that I have been given the opportunity to participate in my employer's group plan and WAIVE coverage. | |
| Reason for waiving coverage check appropriate box below: | |
| <input type="checkbox"/> Spouse's group health plan <input type="checkbox"/> Government plan <input type="checkbox"/> Medicare <input type="checkbox"/> Indian Health Services <input type="checkbox"/> COBRA <input type="checkbox"/> Medicaid <input type="checkbox"/> SCI | |
| <input type="checkbox"/> Other: Explain _____ | |
| If waiving because you have other coverage please complete: | |
| Policy Holder Name _____ | Policy Holder Employer Name _____ |
| Insurance Carrier _____ | Policy # _____ Phone # _____ |

| SECTION F: Certification (1099 Employees are not eligible) | |
|--|-------------|
| I declare I am an employee regularly scheduled to work AT LEAST 20 HOURS PER WEEK . I (circle one) APPLY FOR / WAIVE coverage offered to me. I understand that services will be available subject to the exclusions, limitations and conditions described in the group member certificate. 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. | |
| Employee Signature: _____ | Date: _____ |