



NEW MEXICO HEALTH INSURANCE ALLIANCE

Full-Time Employment Affidavit

P. O. Box 5095 • Santa Fe, NM 87502-5095
1-800-204-4700 • 505-989-1600 • Fax: 505-988-3461
Website: www.nmhia.com

Any misrepresentation relating to an employer's eligibility as a small employer or to an individual's eligibility for coverage may be grounds for rescission or cancellation of coverage and such other action as may be appropriate under law.

_____ being first duly sworn does hereby state that he/she
(Name)

works for a business known as _____
(Business Name)

for _____ hours per week on a regular basis.

(Signature) (Business Address) (City)

(Social Security Number) (Business Phone)

ON THIS _____ DAY OF _____, 20____ BEFORE ME, PERSONALLY
APPEARED _____ WHO SIGNED THIS
DOCUMENT.

WITNESSED BY: _____
(Notary Not Required)