



NEW MEXICO HEALTH INSURANCE ALLIANCE

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 Website: www.nmhia.com

Group Change Request

Required for all terminated employees: All termination requests must be received in the NMHIA office by the end of the month following the month in which the employee was terminated or his/her coverage cancelled.

Please read the following information before completing this form:

If you are an **EMPLOYER** who wants to make changes to the group policy, please fill out the following sections:

- Section B – Fill in your current information
- Section C – Complete for business name/address changes and sign
- Section F – Please read and sign if you are *terminating the entire group policy*
- Section G – Employer signature required for terminating an employee's coverage

If you are an **EMPLOYEE** who is currently covered with the NMHIA and you want to make changes, please fill out the following sections (*note – if you do not yet have coverage, please fill out the Employee Enrollment/Waiver Form*):

- Sections A & B – Fill in your current information & **PLEASE PRINT CLEARLY**
- Section D – Complete if you are adding/deleting dependents
- Section E – Complete if you are adding dependents to your policy
- Section G – Please read and sign

REQUESTED EFFECTIVE DATE: _____

Authorized Effective Date: _____

SECTION A - Employee Information (Complete all information)			
Employee Name (Last, First, Middle Initial)	Social Security #	Phone #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married

SECTION B - Employer Information (Complete all information)			
Employer/Company Name	NMHIA Account #	Phone Number	Fax Number

SECTION C - EMPLOYER Requested Changes (Please mark all that apply)					
<input type="checkbox"/> Name Change	New Name _____ [Business license or legal documents required]				
<input type="checkbox"/> Ownership Change	If the business has changed owners, a new Employer Group Application must be completed and attached				
<input type="checkbox"/> Address Change <i>(may cause rate change)</i>	Street/Physical Address	City	County	State	Zip
	Mailing Address (if different from above)	City	County	State	Zip
Signature Required: _____					

SECTION D - EMPLOYEE Requested Changes (Please mark all that apply)					
<input type="checkbox"/> Name Change	New Name _____ [Marriage License or other legal documents required]				
<input type="checkbox"/> Address Change	Street/Physical Address	City	County	State	Zip
	Mailing Address (if different from above)	City	County	State	Zip
<i>(If the Individual has moved out of the HMO service area, only emergency services may be available)</i>					
<input type="checkbox"/> Deletions	Reason: _____ If terminating employment, termination Date: _____ (If caused by a divorce, please submit divorce decree and signature of spouse losing coverage)				
<input type="checkbox"/> Self	Name: _____ Reason: _____				
<input type="checkbox"/> Spouse	Name: _____ Reason: _____				
<input type="checkbox"/> Children	Name: _____ Reason: _____				
	Name: _____ Reason: _____				
	Name: _____ Reason: _____				

SECTION D Continued - Employee Requested Changes Please mark all that apply - PRINT CLEARLY

Additions Spouse: Date of Marriage: _____ Newborn Legal Dependent

- Dependents (including spouses) that were not previously waived from coverage will be covered by NMHIA provided that the dependent's name and date of birth is submitted to the NMHIA office within 31 days from date of marriage, birth or legal custody. Those not submitted within the 31 days must wait until the annual policy anniversary date to be added to the policy.
- The effective date for changes will always be the first day of the following month for changes or additions. In cases where you are adding a newborn, adopted or custodial child, coverage begins from date of birth or legal custody provided the proper documentation along with any additional premium is received by the NMHIA office within 31 days from date of birth, adoption or legal custody.

Please fill out the information below for all dependents you are adding to your policy

	Relation	Social Security #	Date of Birth	M /F	Physician Name (HMO plan only)	*Other Coverage
Legal Spouse						
Dependent						
Dependent						
Dependent						

SECTION E: Coordination of Benefits (Please answer all questions)

1. Are you or any dependents covered under another plan? Yes No
If yes, who? _____ Carrier: _____ Effective Date: _____
2. Are you or any dependents applying for coverage under another plan? Yes No
If yes, who? _____ Carrier: _____ Effective Date: _____
3. Are you or any of your dependents eligible or covered by Medicare? Yes No
If "Yes," who?: _____ Beneficiary _____ Effective Date: _____

If "Yes" to the above questions, please provide information requested and fill in **"*Other Coverage"** box above:

SECTION F: EMPLOYER REQUEST TO TERMINATE ENTIRE GROUP POLICY: (Please read and sign)

All requests for termination of group coverage must be made in writing and submitted to NMHIA. **The NMHIA office must receive notice no later than the 10th of the month following the last month of coverage. No premium refunds will be made for written requests received at the NMHIA office after the 10th of the month following the last month of coverage.** NMHIA will send a confirmation of group termination requests to the employer, the carrier, and the broker of record. If an employer terminates group coverage for non-payment of premium or by written request, then the employer may not be eligible for an NMHIA plan for up to three years from the date of termination, unless the Group/Employer experiences a change in eligibility status. Written requests are required to terminate automatic payment withdrawals (Electronic Funds Transfer).

REASON FOR TERMINATING ENTIRE GROUP POLICY: _____

EMPLOYER SIGNATURE: _____ DATE: _____

SECTION G: CERTIFICATION (Please read and sign)

A written request for dependent coverage/qualifying event must be received by the NMHIA office within 31 days of the event or be subject to the conditions of late entrants.

PRIMARY INSURED SIGNATURE: _____ DATE: _____

SPOUSE SIGNATURE: Required in divorce _____ DATE: _____

EMPLOYER SIGNATURE: _____ DATE: _____