



Individual Change Request

NEW MEXICO HEALTH INSURANCE ALLIANCE

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

REQUESTED EFFECTIVE DATE: _____

Approved Effective Date: _____

SECTION A: Primary Insured Information *** PLEASE PRINT CLEARLY & COMPLETE ALL INFORMATION ***			
Name (Last, First, Middle Initial)	Social Security #	Phone #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married

SECTION B: Primary Insured Requested Changes (please mark all that apply)					
<input type="checkbox"/> Name Change	New Name _____ (Marriage, divorce or other legal document 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 are available. If you reside outside of New Mexico for a period of over 6 months, you will no longer be eligible for an NMHIA plan. If your county or state changes your premium may change.</i>					

<input type="checkbox"/> Deletions					
<input type="checkbox"/> Self	Reason: _____	(If divorce, divorce decree required or obituary for death)			
<input type="checkbox"/> Spouse	Name: _____	Reason: _____			
<input type="checkbox"/> Children	Name: _____	Reason: _____			
	Name: _____	Reason: _____			
	Name: _____	Reason: _____			

<input type="checkbox"/> Additions Newborns Must Be enrolled within 31 days of birth	Please check applicable addition: Marriage Certificate, Birth Certificate or other legal document required				
	<input type="checkbox"/> Spouse: Date of Marriage : _____	<input type="checkbox"/> Newborn	<input type="checkbox"/> Legal Dependent		
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 Name						
Dependent Name						
Dependent Name						
Dependent Name						

SECTION C: 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:

Certification

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

No premium refunds will be made for written termination requests received at the NMHIA office after the 10th of the month following the last month of coverage.

PRIMARY INSURED SIGNATURE: _____ **DATE:** _____

SPOUSE SIGNATURE: (Required in event of divorce) _____ **DATE:** _____