New Mexico Health Insurance Marketplace Application for Health Coverage & Help Paying Costs

Apply faster online at www.beWellnm.com

Use this application to see what coverage you qualify for

- BeWellnm plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help lower your premiums for health coverage and possible reduced cost sharing.
- Free or low-cost coverage through Medicaid.
- Certain income levels may qualify for free or low-cost programs.

Who can use this application?

- Use this application to apply for anyone in your household.
- Apply even if you, your spouse, or your child already have health coverage. You could be eligible for free or lower-cost coverage.
- Households that include eligible immigrants can apply. You can apply for your child even if you aren't eligible for coverage.
- If someone is helping you fill out this application, you may need to complete Appendix C.

What you may need to apply

- Social Security Numbers (SSNs) (or document numbers for any eligible immigrants who need coverage).
- Employer and income information for everyone in your household (like from pay stubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your household.

Why do we ask for this information?

- We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, visit www.beWellnm.com.

Get help with this application

Send your complete, signed application to the address on page 13. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you within 1–2 weeks, and **you may get a call from beWellnm if we need more information.** You'll get an eligibility notice by your preferred contact method after your application is processed. If you don't hear from us, contact the Customer Engagement Center. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** www.beWellnm.com.
- **Phone:** Call the beWellnm Customer Engagement Center at **1-833-862-3935**. TTY users can call **711**.
- **In-person:** There may be brokers or enrollment counselors in your area who can help. Visit www.beWellnm.com, or call the beWellnm Customer Engagement Center at **1-833-862-3935** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-833-862-3935**.
- **Other languages:** If you need help in a language other than English, call **1-833-862-3935** and tell the Customer Engagement Center representative the language you need. We'll get you help at no cost to you.

You have the right to get beWellnm information in an accessible format, like large print or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.bewellnm.com/nondiscrimination-and-accessibility/, or call the beWellnm Customer Engagement Center at **1-833-862-3935** for more information. TTY users can call **711**.

Please print in capital letters using black or dark blue ink only.
Fill in the circles ○ like this ●.

STEP 1: Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name ______ Middle name ______

Last name ______ Suffix ______

2. Home address (Leave blank if you don't have one.) ______ 3. Address 2 ______

4. City ______ 5. State ______ 6. ZIP code ______ 7. County ______

8. Mailing address (if different from above - include even if homeless) ______

10. City ______ 11. State ______ 12. ZIP code ______ 13. County ______

14. Do you intend to reside in New Mexico? ○ Yes ○ No

15. Phone number (______) ______ - ______ Extension ______ Phone Type ○ Home ○ Work ○ Cell

16. Second Phone number (______) ______ - ______ Extension ______ Phone Type ○ Home ○ Work ○ Cell

17. Email address ______

18. Preferred language:

Written ________ Spoken ________

19. Do you want to get information about this application by:

- ○ Paper notice ○ Email ○ Text

STEP 2: Tell us about your household.

Who do you need to include on this application?

Complete the Household Relationship Table and then Step 2 for each person in your household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your household and your household income. If you don’t include someone, even if they already have health coverage, your eligibility results could be affected.

For adults who need coverage:

Include these people ***even if they aren’t applying for health coverage for themselves:***

- Any spouse
- Any child under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's/guardian's tax return). You don’t need to file taxes to get health coverage.

For children under age 21 who need coverage:
*Include these people **even if they aren't applying for health coverage themselves:***

- Any parent, stepparent, or guardian they live with
- Any sibling they live with
- Any child they live with, including stepchildren
- Any spouse they live with
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

Tell us about your household: Write each member of your household in the Household Relationship Table below. Use the Sample Table here as a guide. Your income and household size help us decide the programs and benefits for which you qualify.
Sample Household Relationship Table:

PERSON 1 Maria is the

Wife	Mother			
Of PERSON 2	Of PERSON 3	Of PERSON 4	Of PERSON 5	Of PERSON 6

PERSON 2 John is the

Husband	Stepfather			
Of PERSON 1	Of PERSON 3	Of PERSON 4	Of PERSON 5	Of PERSON 6

PERSON 3 Lily is the

Daughter	Stepdaughter			
Of PERSON 1	Of PERSON 2	Of PERSON 4	Of PERSON 5	Of PERSON 6

Household Relationship Table

Use the table below to list each person in your household and how they are related to each other. If you need more space, you can draw more columns and rows, or make a copy of the table.

Start with **Person 1,** and fill in the relationship that **Person 1** has to each member of the household.

Person 1 is the main contact person for this application.

Repeat this step for **each person** listed in the household.

Only use the terms husband, wife, or spouse when describing people who are legally married ("legally married" includes common law and common law registered, but does not include civil unions).

Person 1 ____________________ **Person 2** ____________________

Person 3 ____________________ **Person 4** ____________________

Person 5 ____________________ **Person 6** ____________________

PERSON 1 is the

________	________	________	________	________
Of PERSON 2	Of PERSON 3	Of PERSON 4	Of PERSON 5	Of PERSON 6

PERSON 2 is the

________	________	________	________	________
Of PERSON 1	Of PERSON 3	Of PERSON 4	Of PERSON 5	Of PERSON 6

PERSON 3 is the

___________	___________	___________	___________	___________
Of PERSON 1	Of PERSON 2	Of PERSON 4	Of PERSON 5	Of PERSON 6

PERSON 4 is the

___________	___________	___________	___________	___________
Of PERSON 1	Of PERSON 2	Of PERSON 3	Of PERSON 5	Of PERSON 6

PERSON 5 is the

___________	___________	___________	___________	___________
Of PERSON 1	Of PERSON 2	Of PERSON 3	Of PERSON 4	Of PERSON 6

PERSON 6 is the

___________	___________	___________	___________	___________
Of PERSON 1	Of PERSON 2	Of PERSON 3	Of PERSON 4	Of PERSON 5

Note: If someone in your household has passed away in the year you are applying for coverage, you should still include them on your application but not as Person 1. This will help us better determine what benefits you may qualify for. You **DO NOT** have to include other unrelated roommates.

Complete Step 2 for each person in your household.

Start with yourself, then add other adults and children. If you have more than 2 people in your household, **you'll need to make a copy of the pages and attach them.**

You don't need to provide immigration status or Social Security Numbers (SSNs) for household members who don't need health

coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 **(Start with yourself.)**

Complete Step 2 for yourself, your spouse/partner and dependents who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add the people in your household.

1. First name

Middle name

Last name

Suffix

2. Relationship to PERSON 1?

3. Are you married?
- Yes
- No

4. Date of birth (mm/dd/yyyy)

5. Sex
- Female
- Male

6. **Social Security Number (9-digit SSN)**

Do you have a different name on your SSN card?

First name:

Last name:

If you do not have an SSN, select why not:
- Illness exemption
- Just applied
- Non-citizen exemption

Religious exemption Other:

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **www.socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't usually file a federal income tax return. You will need to file if you receive tax credits.*

YES. If yes, answer items a through c. **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? Yes No

If yes, write name of spouse:

If no, are you filing separately because you are a victim of domestic abuse or are an abandoned spouse? Yes No

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, list the name of the tax filer:

How are you related to the tax filer:

8. Are you pregnant? Yes No

If yes, how many babies are expected during this pregnancy?

If yes, what is the due date (mm/dd/yyyy)?

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*

- **YES.** Continue with application.
- **NO. If no,** SKIP to the income questions starting on page 4.

10. Do you have a physical disability or mental health condition that limits your ability to work, attend school, or take care of your daily needs? Yes No

11. Do you have a physical, mental, or emotional health condition that limits daily activities (like bathing, dressing, daily chores, etc.), or live in a medical facility or nursing home? Yes No

12. Do you need a reasonable accommodation because of a disability or an injury? Yes No

If yes, condition:

Accommodation

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13. Are you a **U.S. citizen or U.S. national?** Yes No

14. Are you a **naturalized** or **derived citizen?** *(This usually means you were born outside of the U.S.)* Yes No

If yes: Certificate of Naturalization

Certificate of Citizenship

Enter USCIS/alien number below as well.

15. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? **YES.** Enter ID number. **No**

Immigration document type

Status type

Status award date

Write your full name as it appears on your immigration document.

USCIS/Alien or I-94 number (11 characters)

Card number or passport number (13 characters)

SEVIS ID or expiration date (12 characters)

Visa number (8 characters)

Other (category code or country of issuance)

- I do not have my document details available at this time.

a. Did you arrive in the U.S. after August 22, 1996? Yes No

b. Are you, or your spouse or parent, an honorably discharged veteran or active-duty member of the U.S. military? Yes No

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16. Do you want help paying for medical bills from the last 3 months?

Yes No

17. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Fill in "yes" if you or your spouse takes care of this child.)* Yes No

List the names and relationships of any children under 19 that live with you in your household:

18. Were you a full time student? Yes No

19. Were you ever in foster care? Yes No

If yes, what state?

If yes, were you getting coverage through a state Medicaid program?

Yes No

If yes, how old were you when you left the foster care system?

Optional: *(Fill in all that apply.)*

20. Hispanic ethnicity: Mexican, Mexican-American, or Chicano/a

Puerto Rican Cuban Other:

21. Race: Asian Indian American Indian or Alaska Native

Black or African American Chinese Filipino

Guamanian or Chamorro Japanese Korean

Native Hawaiian Other Asian Other Pacific Islander

Samoan Vietnamese White Other:

Current job & income information

Employed: If you're currently employed, tell us about your income. Start with item 22.

Not employed: Skip to item 30.

Self-employed: Skip to item 29.

Current job 1:

22. Employer name

a. Federal Tax ID (optional)

b. Employer address

c. Apt/Unit Number

d. City

e. State

f. ZIP code

g. County

23. Wages/tips (before taxes) ○ One time only ○ Weekly
○ Two Weeks ○ Twice a month ○ Monthly
$ ○ Every other month ○ Quarterly
○ Twice a year ○ Yearly

If one time only: Month Year

24. Average hours worked each WEEK

Current job 2: *(If you have additional jobs and need more space, attach another sheet of paper.)*

25. Employer name

a. Federal Tax ID (optional)

b. Employer address

c. Apt/Unit Number

d. City

e. State

f. ZIP code

g. County

26. Wages/tips (before taxes) ○ One time only ○ Weekly
○ Two Weeks ○ Twice a month ○ Monthly
$ ○ Every other month ○ Quarterly
○ Twice a year ○ Yearly

If one time only: Month Year

27. Average hours worked each WEEK

28. In the past year, did you/have you had: ○ Change jobs
○ Stop working ○ A change in hours ○ Wage/salary change

A marriage, legal separation, or divorce

A death in the family

None of these

29. **If self-employed, answer a through c:**

a. Type of work:

b. Profit / Loss — How much net income (profits once business expenses are paid) will you get or how much will you lose from this self-employment this **month?**

c. Average hours worked each WEEK

30. **Other income you get this month:** Fill in all that apply, and give the amount and how often you get it. **Fill in here if none. NOTE:** *You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).*
*If a payment is **one time only, write in the month and year.***

Unemployment
$ How often?

Pension/Retirement Source:
$ How often?

Social Security
$ How often?

Net capital gains (monthly)
$

Other income, type:
$ How often?

- Alimony received *(Note: Only for divorces finalized before 01/01/2019.)*

  $ ______ How often? ______

- Net farming/fishing Source: ______

  $ ______ How often? ______

- Net rental/royalty ○ Loss ○ Profit

  $ ______ How often? ______

- Interest, dividends, or other investment income

  $ ______ How often? ______

31. **Deductions**: Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: *You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 29b).*

Yearly alimony paid (***Note:*** *Only for divorces finalized before 01/01/2019.)* $ ______

Yearly student loan interest $ ______

Other yearly deductions: ______ $ ______

32. **Complete this question if your income changes during the year,** like if you only work at a job for part of the year or receive a bonus for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total projected income for the calendar year for which you are applying for coverage:

$

Year:

STEP 2: PERSON 2

Note: If this person doesn't need health coverage, just answer questions 1-13 on this page. Make a copy of pages 6-8 if there are more than 2 people in your household. Label them as PERSON 3, PERSON 4, etc.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. You will need to file taxes if you receive tax credits. See page 1 for more information about who to include.

1. First name

Middle name

Last name

Suffix

2. Relationship to PERSON 1?

3. Are you married?

Yes No

4. Date of birth (mm/dd/yyyy)

5. Sex

Female Male

6. Do you intend to reside in New Mexico? Yes No

7. **Social Security Number (9-digit SSN)**

Do you have a different name on your SSN card?

First name: Last name:

If you do not have an SSN, select why not:

- Illness exemption
- Just applied
- Non-citizen exemption
- Religious exemption
- Other:

We need this SSN if you want health coverage for PERSON 2, and PERSON 2 has an SSN.

8. Does PERSON 2 live at the same address as PERSON 1?

Yes No **If no**, list address below:

Street address

City State ZIP code County

If no, does PERSON 2 live with a parent, stepparent, or guardian?

Yes No

If yes, what is the name of the parent, stepparent, or guardian?

9. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?** *(You can still apply for coverage even if PERSON 2 don't usually file a federal income tax return. You will need to file if you receive tax credits.)*

YES. If yes, answer items a through c. **NO. If no,** skip to item c.

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, write name of spouse:

If no, are you filing separately because you are a victim of domestic abuse or are an abandoned spouse? Yes No

b. Will PERSON 2 claim any dependents on your tax return?

Yes No

If yes, list name(s) of dependents:

c. Will PERSON 2 be claimed as a dependent on someone's tax return?

Yes No

If yes, list the name of the tax filer:

How is PERSON 2 related to the tax filer:

10. Is PERSON 2 pregnant? Yes No

If yes, how many babies are expected during this pregnancy?

If yes, what is the due date (mm/dd/yyyy)?

11. **Does PERSON 2 need health coverage?** *(Even if PERSON 2 has coverage, there might be a program with better coverage or lower costs.)* **YES.** Continue with application.

NO. If no, SKIP to the income questions starting on page 7.

12. Does PERSON 2 have a physical disability or mental health condition that limits their ability to work, attend school, or take care your daily needs? Yes No

13. Does PERSON 2 have a physical, mental, or emotional health condition that limits daily activities (like bathing, dressing, daily chores, etc.), or live in a medical facility or nursing home?

Yes No

Note: If a person needs help only because they're too young to do these things for themselves, don't select 'yes' to Q11 and Q12.

14. Does PERSON 2 need a reasonable accommodation because of a disability or an injury? Yes No

If yes, condition:

Accommodation

15. Is PERSON 2 a **U.S. citizen or U.S. national?** Yes No

16. Is PERSON 2 a **naturalized** or **derived citizen?** *(This usually means you were born outside of the U.S.)* Yes No

If yes: Certificate of Naturalization

Certificate of Citizenship

Enter USCIS/alien number below as well.

17. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do you have eligible immigration status? **YES.** Enter ID number. **No**

Immigration document type

Status type

Status award date

Write PERSON 2's full name as it appears on their immigration document.

USCIS/Alien or I-94 number (11 characters)

Card number or passport number (13 characters)

SEVIS ID or expiration date (12 characters)

Visa number (8 characters)

Other (category code or country of issuance)

Person 2 does not have their document details available at this time.

a. Did PERSON 2 arrive in the U.S. after August 22, 1996? Yes No

b. Is PERSON 2, or PERSON 2's spouse or parent, an honorably discharged veteran or active-duty member of the U.S. military?

Yes No

18. Does PERSON 2 want help paying for medical bills from the last 3 months? Yes No

19. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? *(Fill in "yes" if PERSON 2 or their spouse takes care of this child.)* Yes No

List the names and relationships of any children under 19 that live with PERSON 2 in their household:

20. Is PERSON 2 a full time student? Yes No

21. Was PERSON 2 ever in foster care? Yes No

If yes, what state?

If yes, were you getting coverage through a state Medicaid program?

Yes No

If yes, how old were you when you left the foster care system?

Optional: *(Fill in all that apply.)*

22. Hispanic ethnicity: Mexican, Mexican-American, or Chicano/a

Puerto Rican Cuban Other:

23. Race: Asian Indian American Indian or Alaska Native

Black or African American Chinese Filipino

Guamanian or Chamorro Japanese Korean

Native Hawaiian Other Asian Other Pacific Islander

Samoan | Vietnamese | White | Other: ____

Current job & income information

- **Employed:** If PERSON 2 is currently employed, tell us about your income. Start with item 24.
- **Not employed:** Skip to item 32.
- **Self-employed:** Skip to item 31.

Current job 1:

24. Employer name ____ a. Federal Tax ID (optional) ____

b. Employer address ____ c. Apt/Unit Number ____

d. City ____ e. State ____ f. ZIP code ____ g. County ____

25. Wages/tips (before taxes) $ ____

One time only | Weekly | Two Weeks | Twice a month | Monthly | Every other month | Quarterly | Twice a year | Yearly

If one time only: Month ____ Year ____

26. Average hours worked each WEEK ____

Current job 2: *(If PERSON 2 has additional jobs and needs more space, attach another sheet of paper.)*

27. Employer name ____ a. Federal Tax ID (optional) ____

b. Employer address

c. Apt/Unit Number

d. City

e. State

f. ZIP code

g. County

28. Wages/tips (before taxes)
- One time only
- Weekly
- Two Weeks
- Twice a month
- Monthly
- Every other month
- Quarterly
- Twice a year
- Yearly

$

If one time only: Month Year

29. Average hours worked each WEEK

30. In the past year, did PERSON 2/has PERSON 2 had:
- Change jobs
- Stop working
- A change in hours
- Wage/salary change
- A marriage, legal separation, or divorce
- A death in the family
- None of these

31. **If self-employed, answer a through c:**

a. Type of work:

b. Profit / Loss — How much net income (profits once business expenses are paid) will PERSON 2 get or how much will PERSON 2 lose from this self-employment this month?

c. Average hours worked each WEEK

32. **Other income you get this month:** Fill in all that apply, and give the amount and how often PERSON 2 gets it. **Fill in here if none.**

NOTE: *You **don't** need to tell us about PERSON 2's income from child support, veteran's payments, or Supplemental Security Income (SSI). If a payment is **one time only, write in the month and year.***

- Unemployment
  $ ______ How often? ______
- Pension/Retirement Source: ______
  $ ______ How often? ______
- Social Security
  $ ______ How often? ______
- Net capital gains (monthly)
  $ ______
- Other income, type: ______
  $ ______ How often? ______
- Alimony received *(Note: Only for divorces finalized before 01/01/2019.)*
  $ ______ How often? ______
- Net farming/fishing Source: ______
  $ ______ How often? ______
- Net rental/royalty
  $ ______ How often? ______
- Interest, dividends, or other investment income
  $ ______ How often? ______

33. **Deductions**: Fill in all that apply, and give the amount and how often PERSON 2 pays it. If PERSON 2 pays for certain things that can be

deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: *You shouldn't include child support that PERSON 2 pays, or a cost already considered in the answer to net self-employment (question 30b).*

Yearly alimony paid (***Note:*** *Only for divorces finalized before 01/01/2019.)* $

Yearly student loan interest $

Other yearly deductions: $

34. **Complete this question if PERSON 2's income changes during the year,** like if PERSON 2 only works at a job for part of the year or receives a bonus for certain months. If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total projected income for the calendar year for which they are applying for coverage:

$

Year:

STEP 2: Household living arrangement & American Indian or Alaska Native (AI/AN) household member(s)

1. What is your household living arrangement (ex., at home, homeless, substance abuse treatment, etc.)?

PERSON 1 (Yourself)	PERSON 2	PERSON 3

PERSON 4	PERSON 2	PERSON 3

2. **Are you or is anyone in your household American Indian or Alaska Native?**

- ◯ **NO. If no,** continue to Step 4.
- ◯ **YES. If yes,** continue to Step 4, plus complete **Appendix B** and include with application.

STEP 4: Your household's health coverage

1. **For every year that you got a premium tax credit, did your household file a tax return and reconcile any premium tax credit you used?** ◯ **YES, premium tax credits were reconciled. Fill in the circle only if ALL of these apply to you:**

- You used advance payments of the premium tax credit (APTC) in one or more past years to help lower your costs for health insurance coverage through a marketplace.
- The tax filer for your household filed a federal income tax return for each of these years.
- The tax filer(s) submitted IRS Form 8962 with the tax return. For more information, visit **www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments**

2. **Was anyone on this application found not eligible for Medicaid in the past 90 days?** *(Select yes only if someone was found not eligible for this coverage by the New Mexico Human Services Dept.)*

◯ Yes ◯ No

Who? ______________________

If yes, has the household income, household size, citizenship/immigration status, residency, physical disability, pregnancy status, or mental health status changed for them since they were found eligible for Medicaid? ◯ Yes ◯ No

Who?

3. **Is anyone on this application applying for coverage during or following the beWellnm Open Enrollment Period or after a qualifying life event?** *(If yes and it was during a Qualifying Life Event, complete **Appendix D**.)* ◯ Yes ◯ No

Who?

4. If anyone applying for coverage is eligible for Medicaid, which Managed Care Organization would they like - **Blue Cross Blue Shield, Presbyterian, or Western Sky**? (They can switch to a different one within 3 months if they want or if their selection is no longer available at time of application.)

PERSON 1 (Yourself)	PERSON 2	PERSON 3
PERSON 4	PERSON 2	PERSON 3

5. **Is anyone listed on this application offered health coverage from a job?** *Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.*

◯ **YES.** Continue and then complete **Appendix A.** ◯ **NO**

Is anyone listed on the application offered an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer HRA (QSEHRA)? ***If yes,*** *fill out* ***Appendix F.*** ◯ Yes ◯ No

6. **Is anyone enrolled in health coverage now?**

○ **YES. If yes,** continue to question 7. ○ **NO. If no,** SKIP to Step 5.

7. **Information about current health coverage.** *(Make a copy of this page and the next page if more than 2 people have health coverage now.)*

Select the type of coverage you **will still be enrolled** in when your coverage through beWellnm may start. *(Don't tell us about TRICARE if you have Direct Care or Line of Duty. Other full benefit coverage does **not** include Marketplace coverage.)*

PERSON 1: Name of person enrolled in health coverage

Type of coverage: *[If employer insurance, including COBRA or Retiree, complete **Appendix A**; all other types, complete **Appendix E**.]*

○ Employer insurance ○ COBRA ○ Retiree Health Plan ○ Medicaid

○ Medicare ○ TRICARE ○ Veterans Affairs Health Program

○ Peace Corps/Federal Employees Health Benefit Program

○ Other full benefit coverage ○ Other limited benefit coverage

If it's employer insurance:

Name of health plan

Policy/ID number

Date when PERSON 1 could/did start coverage (mm/dd/yyyy):

PERSON 2: Name of person enrolled in health coverage

Type of coverage: *[If employer insurance, including COBRA or Retiree, complete **Appendix A**; all other types, complete **Appendix E**.]*

- Employer insurance
- COBRA
- Retiree Health Plan
- Medicaid
- Medicare
- TRICARE
- Veterans Affairs Health Program
- Peace Corps/Federal Employees Health Benefit Program
- Other full benefit coverage
- Other limited benefit coverage

If it's employer insurance:

Name of health plan

Policy/ID number

Date when PERSON 2 could/did start coverage (mm/dd/yyyy):

STEP 5: Your agreement & signature

1. If any household members appear to be eligible for Medicaid, we will send this application to the New Mexico Human Services Department (HSD) for a final determination of Medicaid eligibility.
2. If it looks like all or some household members are not eligible for Medicaid, do you still want us to send this application to HSD for a final determination of Medicaid eligibility? ◯ Yes ◯ No
3. If you have questions, please contact our Customer Engagement Center at 1-833-862-3935 (TTY: 711). ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is awaiting trial.

This application will be used to determine eligibility for subsidized or unsubsidized health insurance coverage offered through the New Mexico Health Insurance Exchange, also known as beWellnm (hereinafter, "beWellnm"), and other coverage programs, such as Medicaid.

On behalf of myself and all of the people listed on this application I understand, represent and agree as follows:

If anyone on this application is enrolled in coverage through beWellnm (i.e., Marketplace coverage) and is later found to have other qualifying health coverage (like Medicare or Medicaid), beWellnm will automatically end their Marketplace plan coverage. This will help make sure that anyone who's found to have other qualifying coverage won't stay enrolled in Marketplace coverage and have to pay full cost.

- [ ] I agree to allow beWellnm to end the Marketplace coverage of the people on my application.
- [ ] I don't give beWellnm permission to end Marketplace coverage in this situation. I understand that the affected people on my application will no longer be eligible for financial assistance and must pay full cost for their Marketplace coverage.

Do you agree to allow beWellnm to use your income data, including information from tax returns, for the next 5 years? ○ Yes ○ No

To make it easier for beWellnm to determine your eligibility for help paying for coverage in future years, you can agree to allow beWellnm to use your updated income data, including information from tax returns, to determine your eligibility for health coverage programs. BeWellnm will send you a notice and let you make any necessary changes to your information. BeWellnm may ask you to confirm that your income still qualifies. You can opt out at any time.

On behalf of myself and all of the people listed on this application I further understand, represent, and agree as follows:

1. I may have to pay a premium for health insurance coverage for myself and others listed on this application. If I fail to pay any premium due, my coverage may be terminated.
2. BeWellnm may share the status of my application with a hospital, community health center, other medical provider or federal or state agencies when necessary for treatment, payment, operations or the administration of the programs listed herein, such as Medicaid.
3. All applicants and members must tell beWellnm about any changes in their household income, employment or size, health insurance coverage, and immigration status, or about changes in any other information on this application (and any supplements to it), within

coverage, and immigration status, or about changes in any other information on this application (and any supplements to it), within thirty (30) calendar days of learning of the change. I can report changes in any of the following ways:

- Sign onto my account at www.beWellnm.com. I can create an online account if I don't already have one.
- Call the beWellnm Customer Engagement Center at 1-833-862-3935 (TTY: 711).
- Send the change information to beWellnm at PO Box 25247, Albuquerque, NM 87125.

A change in information could affect eligibility for any or all household member

4. In connection with the eligibility and enrollment processes, beWellnm may send notices that have personal information about people listed on this application to other people on this application, or otherwise share such personal information with such people.
5. I agree to allow beWellnm to use income data, including information from tax returns, for the next 5 years to decide if I am eligible for health coverage programs. beWellnm will check to make sure I am still eligible, and may ask me to confirm that my income still qualifies. beWellnm will send me a notice and let me make changes to my eligibility application.
    - I can opt out of this provision by not requesting financial assistance at renewal or anytime during the year. (This will impact my ability to get help paying for coverage at renewal). I can review **beWellnm's Privacy Policy** for more information about how tax return information is used.

6. If I am eligible for advanced payments of the premium tax credit, these payments will be made directly to my insurance carrier(s). If I accept advance payments of premium tax credits, it may impact my annual tax liability. I can apply all, some, or none of any premium tax credit amount that I may be eligible for to my monthly premium.
7. BeWellnm will check electronic data sources to see if it can verify my income and other information that I put on this application. These electronic data sources may be from the Social Security Administration (SSA), a consumer reporting agency, and/or other private or government sources. If the information doesn't match, I may have to send confirmation (proof) to beWellnm.
8. BeWellnm may get any records or information to verify information that I put on this application (and any supplements to it), or other information I give once I am a member, to support continued eligibility. I give permission to submit this application for health insurance benefits for all adults and all minor children listed on this application, in accordance with any representations I have made and as allowed by any legal documents I have submitted with this application.
9. If anyone on this application is applying for Medicaid, my signature on this application is also an indication of the following:
    - I am declaring the identity of the children under age 16 for whom I am applying.
    - If asked, I will give proof of things I report to the New Mexico Human Services Department (HSD). If I cannot get proof, I know that I can ask HSD to help me, and I will let HSD contact other people and companies to get proof.
    - I will let HSD give limited information to approved agencies

that offer related assistance for which I may be eligible.

- I understand that if I receive SNAP, Cash, or LIHEAP benefits for which I am not eligible, I may have to pay back HSD for those benefits.
- I know that HSD will check the information that I give. HSD may use computers or other ways to check the information on this form.
- I know that HSD will check the immigration status of people who apply for or get benefits. I understand that immigration status for any household member that I am applying for may be subject to verification by USCIS U.S. Citizenship and Immigration Services (INS) and that it may affect the household's eligibility and/or level of benefits.
- I understand that I must cooperate with Quality Control (QC). QC is a part of HSD. QC reviews cases to make sure that HSD correctly determines who can get help.
- I have been given an opportunity to review my rights and responsibilities, including fair hearing rights and more.
- TRUSTS - I understand that if I, or the person(s) for whom I am applying, have set up a trust or are the beneficiaries of a trust, I must give HSD a copy of the trust document, including all attachments and related information. HSD will analyze the trust to see if it affects the Medicaid benefits for which I am applying.
- ESTATE RECOVERY - I understand that after my death, HSD can file a claim against my estate to recover the amounts that the state pays or paid on my behalf for medical assistance provided under the Medicaid program. This process is called "Estate Recovery." Estate Recovery is required by federal and state law where Medicaid recipients are 55 years of age or

older and the state makes medical assistance payments on their behalf for nursing facility services, home and community-based services, and/or related hospital and prescription drug services. The amount recovered by HSD will not exceed the amount of medical assistance payments made on behalf of the Medicaid recipient. Some exclusions may apply.

- A person who is applying for or receiving Medicaid shall assign to HSD all rights against any and all individuals for medical support or payments for medical expenses paid on the applicant's or recipient's behalf and the behalf of any other person for whom application is made or assistance is received.
- If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- If a child on this application has a parent living outside of the home, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
- I, as the Authorized Representative, affirm and agree to be legally bound to maintain the confidentiality of any information regarding the applicant or beneficiary, shall not reassign any provider claims, if applicable, and shall adhere to all requirements set forth at 42 CFR §435.923(d).

○ I agree to the above statements.

I also understand, represent, and agree as follows:

1. I have read (or have had read to me) and I understand the information on this application, including any supplements and instruction pages.
2. I have permission from all of the people on this application (or their parent or other legally-authorized representative) to submit this application, and to act on their behalf to complete any ongoing or subsequent (later) eligibility and enrollment processes and activities, including (but not limited to), the following:

    - providing personal information about them, including health, health coverage, and income information; seeing such information as may be provided by beWellnm; and providing consent on their behalf to the use and disclosure of their information as described in this application;
    - making choices about coverage options and methods of communication with beWellnm;
    - making changes to the application or other eligibility documents and providing information about any change in their circumstances; and
    - providing consent on their behalf to the use of government and private sources to verify information as described in this application.

3. I understand the rights and responsibilities of everyone listed on this application, as explained herein. I have told or will tell all such persons (or their parent or legally authorized representative, if applicable), about these rights and responsibilities so they understand them.
4. All information I give to beWellnm is confidential. Confidential information may be released to federal or state agencies to determine eligibility and/or to provide services.
5. The information I gave on this application is true, correct, and

complete to the best of my knowledge. I'm signing this application under penalty of perjury, which means that I may be subject to penalties under state and/or federal law if I intentionally make false statements or hide information.

6. Under federal law, beWellnm is prohibited from discriminating against me on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination at: https://www.hhs.gov/ocr/complaints/index.html.
7. beWellnm will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature.

○ I agree to the above statements.

I have reviewed, understand and agree to the Terms of Use **(Appendix G)** and the Privacy Policy **(Appendix H)**. I understand this is necessary for beWellnm to process my paper application into the beWellnm online system.

○ I agree to the above statements.

What should I do if I think my eligibility notice is wrong?

If you do not agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer or other individual. Or, you can request and participate in your appeal on your own.

- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your beWellnm eligibility results, visit www.beWellnm.com/financial-help/consumer-forms/. Or call the beWellnm Customer Engagement Center at 1-833-ToBeWell (1-833-862-3935) and TTY: 711. You can also mail an appeal request form or your own letter requesting an appeal to beWellnm, Appeals Department, PO BOX 25247, Albuquerque, NM 87125. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, and Medicaid, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you are eligible for. You will need to appeal with the state Medicaid agency for eligibility issues with those programs.

By providing my Signature below, I certify under penalty of perjury that the information I have given on this application is true, correct, and complete to the best of my knowledge.

PERSON 1 should sign this application. If you're an **authorized representative**, you may sign here as long as **PERSON 1** signed **Appendix C**. If a certified Broker or Enrollment Counselor has helped you with this application, you will also need to fill out **Appendix C**.

Signature	**Date (mm/dd/yyyy)**

If you're signing this application **outside of Open Enrollment**, make sure you complete **Appendix D** ("Questions about life changes").

STEP 6: Provide completed application

Upload your signed application to your online account at
www.beWellnm.com

Mail your signed application to:
beWellnm
PO Box 25247
Albuquerque, NM 87125

Fax your signed application to:
1-505-216-7776

If you want to register to **vote**, visit
https://portal.sos.state.nm.us/OVR/webpages/InstructionsStep1.aspx
or call **1-800-477-3632.**

Get help in a language other than English

If you, or someone you're helping, has questions about beWellnm, you have the right to get help and information in your language at no cost to you. To talk to an interpreter, call **1-833-862-3935 (TTY: 711).**

Here's a listing of the available languages and the same message provided above in those languages:

Spanish
ATENCIÓN: Usted tiene derecho a recibir ayuda e información en su idioma sin costo alguno. Para obtener ayuda en español, llámenos al 1-833-862-3935 (Teléfono para Personas Sordomudas: 711).

Navajo
Baa ákónízin: Nibee házáánii áté díí t'áá nizaad t'áá jiík'éh bee nił ch'íhodoot'áálígíí. 'Ákoo Diné k'ehjí nił hodoonihgo éí kójí' nihich'į' hodíílnih, 1-833-862-3935 (TTY: 711).

Vietnamese
LƯU Ý: Quý vị có quyền được nhận hỗ trợ và thông tin bằng ngôn ngữ của mình miễn phí. Để được trợ giúp bằng tiếng Việt, hãy gọi cho chúng tôi theo số 1-833-862-3935 (TTY: 711).

German
ACHTUNG: Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Für Hilfe auf Deutsch rufen Sie uns unter 1-833-862-3935 (TTY: 711) an.

Chinese
请注意：接受免费的翻译服务是您的权力，如您在咨询信息以及办理事物时需要中文翻译，请致电 1-833-862-3935（TTY：711)。

Arabic
انتبه: لك الحق في تلقي المُساعدة والمعلومات بلغتك بدون تكلفة. للمُساعدة باللغة العربية، اتصل بنا على رقم الهاتف 1-833-862-3935 الهاتف المُخصص للصم والبكم: 711

Korean
주의:귀하는 무료로 귀하의 언어로 도움과 정보를 받을 권리가 있습니다. 한국어로 도움을 받으려면 1-833-862-3935(TTY:711)로 전화하십시오.

Tagalog
ATTENTION: Ikaw ay may karapatang tumanggap ng tulong at impormasyon sa iyong wika nang walang gastos. Para sa tulong sa Tagalog, tawagan kami sa 1-833-862-3935 (TTY: 711).

Japanese
注意：あなたは無償であなたの言語でヘルプや情報を受け取る権利を持っています。日本語でのサポートについては、1-833-862-3935（TTY：711）までお電話ください。

French
ATTENTION: Vous avez le droit de recevoir de l’assistance et de l’information dans votre langue gratuitement. Pour l’assistance en Français, téléphonez-nous au 1-833-862-3935 (TTY:711).

Italian
ATTENZIONE: Ha il diritto di ricevere gratuitamente aiuto e informazioni nella sua lingua. Per assistenza in Italiano, chiamate il numero 1-833-862-3935 (TTY: 711).

Russian
ВНИМАНИЕ: Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Чтобы получить помощь на русском языке, позвоните нам по телефону 1-833-862-3935 (TTY: 711).

Hindi
ध्यान दें: आपको सहायता और जानकारी अपनी भाषा में बिना किसी कीमत के प्राप्त करने का अधिकार है। हिंदी में सहायता के लिए, हमें 1-833-862-3935 (TTY:711) पर कॉल करें।

Farsi
توجه: شما حق دریافت کمک و اطلاعات به زبان خود بدون هزینه دارید. برای دریافت کمک به زبان فارسی، با ما به شماره 1-833-862-3935 (TTY:711) تماس بگیرید.

Thai
โปรดทราบ: ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย สำหรับ การขอรับความช่วยเหลือเป็นภาษาไทย โทรถึงเราได้ที่หมายเลข 1-833-862-3935 (TTY: 711)

Appendix A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. **Attach a copy of this page and the next page for each job that offers coverage.**

Tell us about the job that offers coverage.
Make a copy of this page and the next page, and take it to the employer who offers coverage to help you answer these questions.

Employee information

1. Is this coverage from: ○ Former employer - Retiree Health Plan
○ Former employer - COBRA ○ Current Employer

2. Employee name (First, Middle, Last)

3. Employee Social Security Number (SSN, 9-digits)

Employer information

4. Employer/company name

5. Employer Identification Number (EIN, optional, 9 characters)

6. Employer phone number (10-digit) Ext Phone type
○ Home ○ Work ○ Cell

Now, enter the information of the person or department who manages employee benefits. We may contact this person if we need more information:

7. Department we can contact about employee health coverage

8. Employer mailing address (beWellnm may send notices to this address)

Apt/Unit Number

9. City

10. State

11. Zip

12. County

13. Phone number (if different from above - 10 digit)

Extension

Phone type

- Home
- Work
- Cell

14. Email address

---

15. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

- **YES** (Continue)
- **NO** (**EMPLOYER:** STOP and return this form to the employee. **EMPLOYEE:** Return to your application for beWellnm coverage.)

a. **When will the employee be eligible for coverage?** (mm/dd/yyyy)

- I don't know.

b. **Does the employer offer a health plan that covers this employee's spouse or dependent(s)?**

- **YES. If yes,** which people? ◯ Spouse ◯ Dependent(s)
- **NO** (Go to question 16.)

List the names of anyone else in the employee's household who's eligible for coverage from this job.

Name	Date Eligible (mm/dd/yyyy)

Name	Date Eligible (mm/dd/yyyy)

Name	Date Eligible (mm/dd/yyyy)

16. Does the employee expect any changes to the employer's health insurance coverage this year? ◯ Yes ◯ No

If yes, list year

- Employer will no longer offer health coverage.

  If yes, what is the last day this job's coverage will be available to the employee? (mm/dd/yyyy)

  - I don't know.

- Employee plans to drop employer's health coverage.

  If yes, what will be the employee's last day of coverage through this job's health plan? (mm/dd/yyyy)

  - I don't know.

Tell us about the health coverage offered by this employer.

17. Does the employer offer a health plan that meets the minimum value standard?

- ○ **YES** (Go to question 18.)
- ○ **NO** (STOP and return this form to employee.)

18. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Don't include family plans. **NOTE:** If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium: **$** ____________

NOTE: Enter the lowest amount the employee could pay for health coverage.

b. Employee would pay this amount:

○ Weekly ○ Every two weeks ○ Once a month

○ Twice a month ○ Yearly

NOTE: If the premium changes, come back and update your application.

** A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*

Appendix B

American Indian or Alaska Native (AI/AN) Household Member(s)

Complete this appendix if you or a household member are American Indian or Alaska Native and are applying for coverage. Submit this with your "Application for Health Coverage & Help Paying Costs."

Tell us about your American Indian or Alaska Native household member(s). American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1:

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ○ Yes ○ No

   If yes, Tribe name:

   State tribe located in:

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?

   ○ Yes ○ No

AI/AN PERSON 1:

If no, is this person eligible to get services from the Indian Health Service or a Tribal Health Organization?

Yes No

4. Certain money received may not be counted for Medicaid. List any income (amount and how often) reported on your application that includes money from these sources:

a. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties

b. Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)

c. Money from selling things that have cultural significance

$ How often?

AI/AN PERSON 2:

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? Yes No

If yes, Tribe name:

State tribe located in:

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?

Yes No

AI/AN PERSON 2:

If no, is this person eligible to get services from the Indian Health Service or a Tribal Health Organization?

○ Yes ○ No

4. Certain money received may not be counted for Medicaid. List any income (amount and how often) reported on your application that includes money from these sources:

a. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties

b. Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)

c. Money from selling things that have cultural significance

$ __________ How often? __________

Appendix C

Help completing this application

For certified Brokers and Enrollment Counselors only

Complete this section if you're a certified Broker or Enrollment Counselor filling out this application for somebody else.

1. First name, Middle name, Last name, & Suffix

2. Agency/Organization name

3. Phone Number

4. Email Address

5. Zip Code

6. Brokers only: 10-digit NPN number

7. **Enrollment Counselors only** - Access Status: Is this Enrollment Counselor approved to work with you? ○ Yes ○ No

8. **Enrollment Counselors only** - Organization ID (if applicable):

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact beWellnm. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First, Middle, Last name)

2. Authorized Representative Mailing Address

3. Mailing Address 2

4. City

5. State

6. Zip

7. County

8. Authorized Rep Phone number (10-digit)

Extension

Phone type

Home

Work

Cell

9. Organization name (if applicable)

10. ID number (if applicable)

11. Email address

12. Duration of Authorized Representative authority:

The authority given above should be effective date (mm/dd/yyyy)

From

To

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

Signature

Date (mm/dd/yyyy)

Appendix D

Questions about life changes

(You must complete the rest of this application along with this page and the next page. Don't submit these pages by themselves.)
If anyone on this application experienced certain life changes - like losing health coverage, getting married, or having a baby - in the past 60 days (OR expects to lose their health coverage in the next 60 days), fill out the following questions. Certain life changes allow your coverage through beWellnm to start right away. We also recommend you answer these questions if you're applying outside of Open Enrollment.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. If eligible, you can enroll in Medicaid any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Natives can enroll in coverage through beWellnm any time of the year. **Tell us about changes in your household.**

Did anyone in your household lose health coverage or do they expect to lose it? OR, were any of your household members denied Medicaid by the New Mexico's Human Services Dept.? Enter the name(s) if someone has Medicaid now, or if they had Medicaid in the past 60 days. **NOTE:** IF HOUSEHOLD MEMBERS HAVE MEDICAID NOW AND IT IS ENDING BEFORE beWellnm COVERAGE MAY START: Enter today's date as the coverage end date. IF HOUSEHOLD MEMBERS MEDICAID ENDED WITHIN THE PAST 60 DAYS: Enter the last day of

Medicaid coverage as the coverage end date. IF YOUR EMPLOYER HAS COMPLETELY STOPPED CONTRIBUTING TO YOUR COBRA COVERAGE: Enter the name(s) below and enter the last day you received contribution from your employer as the coverage end date.

Name(s)

Date coverage ended or will end (mm/dd/yyyy)

Lost for not paying premiums? Yes No

Chose to cancel the coverage? Yes No

Did any member of your household gain a dependent or become a dependent? Yes No

If yes:

Did anyone recently get married?

Name(s) Date of marriage (mm/dd/yyyy)

Was at least one spouse enrolled in minimum essential coverage at least 1 day in 60 days before the marriage? Yes No

Did at least one spouse live abroad for at least 1 day in 60 days before the marriage? Yes No

Did at least one spouse live in a service area with no Qualified Health Plans sold in the State Health Exchange during the most recent available enrollment period or during the prior 60 days? Yes No

Has there been a birth in your household?

Name(s) Date of Date (mm/dd/yyyy)

Was anyone added to your household through adoption, foster care, or court ordered care? Name(s)

When did the adoption, foster care placement, or court order happen? (mm/dd/yyyy)

Has anyone in your household who was not previously a lawfully present immigrant become a lawfully present immigrant?

Name(s)

Date immigration status changed (mm/dd/yyyy)

Did anyone in your household or will anyone in your household move to a new location within New Mexico?

Name(s)

Date of the move (mm/dd/yyyy)

Is anyone in your household now homeless?

Name(s)

Date when homeless (mm/dd/yyyy)

Did anyone in your household or will anyone in your household move to a new location within New Mexico?

Name(s)

Date of the move (mm/dd/yyyy)

Was the member(s) enrolled in at least 1 day in 60 days before the move?

Name: Yes No

Name: Yes No

Name: ____ Yes No

Name: ____ Yes No

Did the member(s) live abroad for at least 1 day in 60 days before the move?

Name: ____ Yes No

Name: ____ Yes No

Name: ____ Yes No

Name: ____ Yes No

Did the member(s) live in a service area with no Qualified Health Plans sold in the State Health Insurance Exchange during the most recent enrollment period or during the prior 60 days?

Name: ____ Yes No

Name: ____ Yes No

Name: ____ Yes No

Name: ____ Yes No

Was anyone in your household recently released from incarceration or anyone about to be released from incarceration within the next 60 days?

Name(s) ____

Date of the release (mm/dd/yyyy) ____

Is anyone in your household a victim of domestic abuse or abandonment? Name(s) ____

Appendix E

Questions about other health coverage

Having other health coverage can impact your ability to get tax credits. Complete the relevant section(s) below. Use one sheet per person.

NOTE: If you have more people with other health coverage to include, make a copy of this page and attach.

Tell us about other health coverage in your household.

1. First name, Middle name, Last name, & Suffix

a. Enrolled in Medicare or qualifies for Medicare Part A with no monthly premium:

i. Policy/member ID

ii. Coverage start date (mm/dd/yyyy)

iii. Coverage end date (mm/dd/yyyy) (if applicable)

b. Qualifies for Peace Corp health benefits:

i. Coverage start date (mm/dd/yyyy)

ii. Coverage end date (mm/dd/yyyy) (if applicable)

c. Qualifies for TRICARE or Federal Employees Health Benefit (FEHB) Program:

i. Policy/member ID

ii. Coverage start date (mm/dd/yyyy)

iii. Coverage end date (mm/dd/yyyy) (if applicable)

d. Enrolled in a Veterans Affairs (VA) Health Program:

i. Coverage start date (mm/dd/yyyy)

ii. Coverage end date (mm/dd/yyyy) (if applicable)

e. Other full benefit coverage (do not include coverage through beWellnm):

i. What is the health plan called?

ii. Policy number/member ID

f. Other limited benefit coverage (like a school accident policy):

i. What is the health plan called?

ii. Policy number/member ID

NOTE: Individuals should call the beWellnm Customer Engagement Center if they are over 65 and do not qualify for Medicare, only qualify for Premium Payment Medicare Part A and are not enrolled or are enrolled in Medicare but wish to purchase a full price plan. BeWellnm may be able to provide coverage and help paying for costs, in some cases.

Appendix F

Questions about QSEHRAs and ICHRAs

Answer the questions below if an employer of a household member offers Qualified Small Employer Health Reimbursements (QSEHRAs) or Individual Coverage Health Reimbursement Arrangements (ICHRAs).

NOTE: If you have more people with QSEHRAs or ICHRAs to include, make a copy of this page and attach.

Tell us about QSEHRAs and ICHRAs in your household.

1. First name, Middle name, Last name, & Suffix

2. Employer/company name

3. Federal tax ID (optional - 9 digits)

Type:

- ◯ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

  If QSEHRA, go to Question 4.

- ◯ Individual Coverage Health Reimbursement Arrangement (ICHRA)

  If ICHRA, go to Question 8.

QSEHRA Questions

4. Enter the active period for the QSEHRA benefit:

From (mm/yyyy): To (mm/yyyy):

5. Enter the maximum yearly **self-only** coverage benefit allowed through the QSEHRA: $

6. Do you intend to use the allowed family coverage benefits offered by your employer? Yes No

7. Enter the maximum yearly family coverage benefit allowed through the QSEHRA: $

ICHRA Questions

8. Enter the active period for your ICHRA benefit:

From (mm/yyyy): To (mm/yyyy):

9. Enter the maximum yearly **self-only** coverage benefit allowed through the ICHRA: $

10. Do you intend to accept the ICHRA benefit from your employer?

Yes No

Appendix G

Terms of Use (Summary)

When you apply for health coverage through beWellnm, we will transfer the information that you put on your paper application into our state-based exchange application system, which is owned and operated by a third-party, Optum Inc. (the "Company"). This page contains a summary of the Company's Terms of Use for using the application
(referred to herein as the "website").

The Terms of Use describe the rules for using the Company's website. They constitute a legally binding agreement between you and the Company. If you are helping another person use the application, the terms are a legally binding agreement between both the helper and the person being helped and the Company. By using the application, you agree to the most recent version of the Terms of Use, which may change at any time. Changes will be posted on the website.

The Company grants you a personal, limited license to view the content on the website for the sole purpose of collecting information regarding plan and related activities such as, if permitted on this website, applying for a plan. If you breach any of the Terms of Use, your license to the website content will terminate.

By using the website, you agree:

- not to misrepresent your identity or provide us with any false information in any information-collection portion of the website, such as a registration or application page;

- not to take any action intended to interfere with the operation of the website;
- not to share any password assigned to or created by you with any third parties or use any password granted to or created by a third party;
- not to directly or indirectly authorize anyone else to take actions prohibited by the Terms of Use; and
- to comply with all applicable laws and regulations while using the website or the content.

All content on the website is provided on an "as is," "as available" basis. Except as prohibited by applicable law, the Company and third parties, if any, providing the website content disclaim all warranties, whether express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, fitness for a particular purpose and non-infringement.

You agree that the Company and its affiliates, officers, directors, employees and agents will not be liable for damages resulting from your use or inability to use the website or the content on the website. This includes claims based on warranty, contract, tort, strict liability and any other legal theory and covers all losses, including direct or indirect, special, incidental, consequential, exemplary and punitive damages, personal injury, lost profits, or damages resulting from lost data. You agree to use the website at your own risk. If you are dissatisfied with the website or the content, your remedy is to discontinue using the website.

Before seeking legal recourse for any harm you believe you have suffered arising from or related to use of the application, you agree to

inform the Company, in writing, and to give the Company 30 days to cure the harm before initiating any action. You must initiate any cause of action within one year after the claim has arisen, or you may be barred from pursuing any cause of action.

The information and content on the website cannot, and is not intended to, replace the relationship that you have with your health care professionals. The content should not be considered medical advice and is not intended as medical advice. Health information changes quickly. Therefore, you should always confirm information with your health care professionals. The content is for informational, cost-comparison purposes only.

Except as prohibited by applicable law, the Company makes no warranty as to the accuracy, completeness, timeliness, correctness and reliability of any content available through its website.

For access to the full Terms of Use or if you have questions, call 1-833-862-3935 (TTY: 711).

Appendix H

Privacy Policy (Summary)

The New Mexico Health Insurance Exchange, also known as beWellnm ("beWellnm") Privacy Policy tells you what information we collect, why we collect it, what we do with it, and how we protect it. It applies to **www.beWellnm.com**, **www.getcovered.beWellnm.com**, and any other website that we control.

45 CFR § 155.260 authorizes beWellnm to collect Personally Identifiable Information (PII) to determine eligibility for enrollment in qualified health plans, to assess potential eligibility for Medicaid, and to determine eligibility for financial assistance. We collect information necessary to verify identity, citizenship status, residency, income, and incarceration status. This data includes, but is not limited to, demographic data (e.g., name, address, phone number, email), income data (e.g., tax filing status, marriage status, tax dependents), citizenship and immigration data (Social Security Number, Resident Alien Number, incarceration status), disability information, and medical insurance coverage information necessary to facilitate enrollment in coverage or programs. We will not create, collect, use, or disclose PII for any other purposes.

We may use the information you provide in computer matching programs with other entities (such as the Social Security Administration, the Centers for Medicare and Medicaid Services, consumer reporting agencies, issuers of Marketplace plans, Experian (as part of the ID proofing process), and contractors engaged to perform Marketplace functions), in order to make eligibility

determinations, to verify continued eligibility for enrollment in a Marketplace plan, to verify individual identity, or to process appeals of eligibility determinations. We will not knowingly disclose your personal information to a third party, except as provided in our policy. We do not sell any information that you enter into our website or systems.

We also verify the information you provide on the application, communicate with your authorized representative (if you have one), and provide the information to the health plan you select.

We may collect limited information about your visit to our website, including domain, IP address, date and time of visit, pages visited, time spent on pages, etc. We may also use various types of standard website technologies, such as cookies, to help us improve our public education and outreach efforts.

You may choose to share your information with certified enrollment assisters who help consumers. You must explicitly designate the professional using our website, or by calling our Customer Engagement Center. You can change or terminate your designation at any time.

We strictly adhere to a wide range of federal and state privacy and information security-related standards required under the Patient Protection and Affordable Care Act privacy regulations and the National Institute of Standards and Technology Guidelines. We use a variety of security controls to keep our PII private and secure as required by applicable laws. We will take all reasonable steps to ensure the confidentiality, integrity, and availability of your PII that is created, collected, used, or disclosed by beWellnm. Your PII will be used by, or

disclosed to, only those authorized to receive or view it. We will keep your tax return information confidential in accordance with section 6103 of the Internal Revenue Code. 26 U.S.C. § 6103.

We contractually bind Non-Exchange Entities who may have access to your PII to privacy and security standards that are at least as protective as the standards beWellnm has established and implemented for itself.

You have the right to see and correct, if necessary, all of the information that we have about you.

By submitting PII to us or by using our websites, you agree that we may collect, use and disclose any such personal information in accordance with our Privacy Policy or as permitted or required by law. We reserve the right to update the Privacy Policy at any time.