truehealth new mexico

Employee Enrollment/Change Form

EMPLOYER GROUP NAME:	Group Number:	Department/Location:	Date of Hire/Reinstated: ___/___/____ Effective Date: ___/___/____
		Hours Worked Per Week:	Subscriber ID# _____

Are you waiving your employer's group coverage? ☐ Yes, I hereby waive True Health New Mexico medical coverage. Complete Step 2 below, then sign and date form.
Reason for Waiver: Individual exchange plan ☐ Individual off-exchange plan ☐ Another Employer Group Plan ☐ Medicare/Medicaid ☐ Other Coverage ☐ Not Covered ☐

STEP 1: ENROLLMENT EVENTS/CHANGES

Open Enrollment? No ☐ Yes ☐ (if Yes, then skip to Step 2) Special Enrollment Event? No ☐ Yes ☐, date: ___/___/___ COBRA ☐ Six-Month Continuation ☐
Adding a Dependent? No ☐ Yes ☐ Marriage ☐ Birth, Adoption, Placement for Adoption or Foster Care ☐ Court Order ☐ Loss of other coverage ☐ Other: _____

Termination of policy OR Termination of dependent Name: _____ Termination Date: ___/___/____ Reason: Terminated Divorce Death Other: _____

STEP 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security Number (SSN):		DOB: ___/ ____/ ____
Home Address:		Apt./Ste:	City:	State:	ZIP:
Mailing Address (if different then above):		Apt./Ste:	City:	State:	ZIP:
Primary Phone: ( )	Other Phone: ( )		Email Address:		Gender/Sex: M ☐ F ☐

Ethnicity/Race: American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black or African American ☐ Hispanic ☐ White ☐ Multiracial ☐

Do you or any of your dependents prefer a spoken or written language other than English? Yes ☐ No ☐ If yes, please list here:	Do you or any of your dependents require assistance due to a disability? Yes ☐ No ☐ If yes, please describe:

STEP 3: PLAN INFORMATION

Your selection will be limited to the benefit plans made available to you by your employer. Any benefit discrepancies will default to the benefit plan offering selected by your employer. Please review the information in your enrollment materials or check with your benefits coordinator if you are uncertain about the types of benefit plans available to you. Your coverage election will be the health benefit selection made by your employer.

If your employer offers multiple True Health New Mexico plans, select your coverage: HMO ☐ or PPO ☐ Plan Name: _____	Coverage applied for: Employee only ☐ 2-Party ☐ Employee + Child(ren) ☐ Family ☐

STEP 4: DEPENDENT INFORMATION

	First Name	M.I.	Last Name	SSN	Date of Birth	Gender/Sex
Legal Spouse/Domestic Partner						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐

Will you or any other family member listed above continue to be covered by any other insurance company? Yes ☐ No ☐	Insurance Company:	List Name(s):
Do you or any family member listed above have Medicare? Yes ☐ No ☐ Part A ☐ Part B ☐	Member Name:	Medicare Number:

STEP 5: SIGN AND DATE

READ PAGE 2 OF THIS APPLICATION. By signing this application, I attest that I have read both sides of this application and warrant my current and continuing authority to act on behalf of and fully bind all of the above Dependents with respect to every provision of the True Health New Mexico Evidence of Coverage, provided said Evidence of Coverage adheres to both state and federal regulations. If you have questions, please call Customer Service at 1-844-508-4677, Monday through Friday, from 8 a.m. to 5 p.m.

Employee Signature	Date	Employer Signature	Date

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.

STEP 6: IMPORTANT – PLEASE READ CAREFULLY

RELEASE OF CONFIDENTIAL HEALTH INFORMATION

By signing this application, I CONSENT, to the extent permitted by applicable law, to the release of or use of Confidential Health Information (as defined below) by any person or entity including, without limitation, practitioners, pharmacies or pharmacy benefit managers, providers, and insurance companies to True Health New Mexico or its designees for any permitted purpose, including but not limited to insurance eligibility, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment or healthcare operations activities of True Health New Mexico. It is understood that it may be necessary for the parties administering the plan in which I/we are enrolling to obtain and/or provide to others this Confidential Health Information.

I understand that authorizing the disclosure of this Confidential Health Information is voluntary, and signing this authorization can be refused; however, if not signed, the processing of this Application may be delayed or inhibited.

I understand that a full description of True Health New Mexico's privacy and confidentiality policy related to Confidential (also known as Protected) Health Information is available on our website at truehealthnewmexico.com or by calling True Health New Mexico Customer Service at 1-844-508-4677.

I understand my consent, here, does not permit use of Confidential Health Information when an authorization is required by law.

I understand that this authorization is in effect for twenty-four (24) months from the date of this application or before the usual 24 months when written notice is sent to True Health New Mexico to revoke it.

I understand that I may revoke this authorization by writing to: True Health New Mexico, Director of Consumer Operations and Compliance, P.O. Box 37200, Albuquerque, NM 87176.

"Confidential Health Information" includes, with respect to me and/or a covered dependent/minor child, any individually identifiable health information, including but not limited to medical, dental, mental health, substance abuse, communicable disease, Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) related information, as well as any disability or employment related information.

AUTHORITY TO ACT

I hereby represent my current and continuing authority to act on behalf of myself and/or my legal dependent child(ren) with respect to every provision of the Agreement. All information on this Application is correct and true. I know that my information on this form will only be used to enroll myself and my eligible dependents for health coverage and will be kept private as required by law. I understand that upon completion of my enrollment I will receive an True Health New Mexico Evidence of Coverage and Summary of Benefits and Coverage, which contains the benefits, limitations, and exclusions applicable to my healthcare plan.

ACCURACY OF INFORMATION PROVIDED ON THIS APPLICATION

I agree that I have read and understood all questions included on this application. By signing below, I certify that the answers provided are correct, complete and wholly true to the best of my knowledge and belief.

NOTIFICATION OF CHANGES

I know that I must tell True Health New Mexico or my Employer if anything changes (and is different than) what I wrote on this application. I can visit truehealthnewmexico.com or call 1-844-508-4677 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

COVERED BENEFITS

I understand that covered benefits, utilization management procedures, and plan exclusions and limitations are subject to the plan's Evidence of Coverage (EOC) and/or Summary of Benefits and Coverage (SBC). These documents are available at truehealthnewmexico.com/small-group-forms/ and truehealthnewmexico.com/large-group-forms/. I also may contact True Health New Mexico at 1-844-508-4677, Monday through Friday, 8:00 a.m. to 5:00 p.m., to request a printed copy of these documents.

COPY OF APPLICATION & NOTICE OF NON-DISCRIMINATION

I understand that I am entitled to a copy of this signed Application and may contact True Health New Mexico to obtain a copy. Premium, price or charge differentials because of location or age based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. I know that under federal law, discrimination is not permitted on the basis of race, color, creed or religion, national origin, sex, age, sexual orientation, gender identity, or disability.

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Language Assistance Services
Servicios de acceso al idioma

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-508-4677 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-508-4677 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-844-508-4677 (TTY: 711.)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-508-4677 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-508-4677 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-508-4677（TTY：711）。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-508-4677 (رقم هاتف الصم والبكم:711).
Korean	주의 : 한국어를 말할 때 무료로 언어 지원 서비스를 이용할 수 있습니다. 1-844-508-4677 (TTY : 711)로 전화하십시오.
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-508-4677 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-508-4677（TTY: 711）まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-508-4677 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-508-4677 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-508-4677 (телетайп: 711).
Hindi	सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं निःशुल्क, आपके लिए उपलब्ध हैं। 1-844-508-4677 पर कॉल करें (टीटीवी: 711)।
Farsi	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-508-4677 (TTY: 711) تماس بگیرید.
Thai	ความสนใจ: หากคุณพูดภาษาไทยมีบริการให้ความช่วยเหลือด้านภาษาฟรี โทร 1-844-508-4677 (TTY: 711)

Notice of Non-Discrimination and Accessibility
Aviso de no discriminación y accesibilidad

The following is a statement describing nondiscrimination for True Health New Mexico and the services it provides to its clients and members.

- We do not discriminate on the basis of race, color, creed or religion, sexual orientation, national origin, age, disability, or gender in our health programs or activities.
- We provide help free of charge to people with disabilities or whose primary language is not English. To ask for a document in another format such as large print, or to get language help such as a qualified interpreter, please call True Health New Mexico Customer Service at 1-844-508-4677, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY: 1-800-659-8331.
- If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can report a complaint to: True Health New Mexico Compliance Hotline, https://www.lighthouse-services.com/brighthealthgroup. Phone (toll-free): 1-855-208-3766 (English), 1-800-216-1288 (Spanish). Email: Reports@Lighthouse-Services.com. Fax: 1-215-689-3885.

You also have the right to file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone, or by mail:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Phone: Toll-free: 1-800-368-1019, TDD: 1-800-537-7697
- Mail: U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

Aviso de no discriminación y accesibilidad

A continuación presentamos una declaración que resume la norma de no discriminación de *True Health New Mexico* y los servicios que prestamos a nuestros clientes y asegurados.

- No discriminamos por la raza, el color, el credo o la religión, la orientación sexual, el origen nacional, la edad, las discapacidades o el sexo en nuestras actividades o programas de salud.
- Ayudamos gratuitamente a las personas que tienen discapacidades o cuyo idioma nativo no es el inglés. Para pedir un documento en otro formato, como en letra grande, o para recibir la ayuda de un intérprete calificado, favor de llamar al Centro de Atención al Cliente de *True Health New Mexico* al 1-844-508-4677, para los servicios TTY llame al 1-800-659-8331, de lunes a viernes, de las 8:00 de la mañana a las 5:00 de la tarde.
- Si usted cree que no hemos prestado estos servicios o que le hemos discriminado de alguna otra manera por su raza, color, origen nacional, edad, discapacidad o sexo, puede reportar una queja a: *True Health New Mexico* Compliance Hotline, https://www.lighthouse-services.com/brighthealthgroup. Teléfono (gratis): 1-855-208-3766 (inglés), 1-800-216-1288 (español). Correo electrónico: Reports@Lighthouse-Services.com. Fax: 1-215-689-3885.

Además, tiene derecho a presentar una queja directamente al Departamento de Salud y Servicios Humanos de los EE. UU. [*U.S. Dept. of Health and Human Services*] ya sea en línea, por teléfono o por correo:

- En línea: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Los formularios de queja están a su disposición en: http://www.hhs.gov/ocr/office/file/index.html.
- Por teléfono: Línea telefónica gratis: 1-800-368-1019, TDD: 1-800-537-7697
- Por correo: U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201