



Group Health Coverage Employer Application

The **easiest and most efficient method to enroll a group** is to log in to the True Health New Mexico producer portal at truehealthnewmexico.com/my-account-login.aspx and complete enrollment electronically. For non-electronic enrollment, please follow the steps below.

STEP 1: GROUP INFORMATION

Small Group Large Group

Name of Employer Group (Legal Name)		DBA Name (if any)		Requested Effective Date	
Primary/Physical Address of Employer Group		City	State	ZIP Code	County
Mailing/Billing Address of Employer Group (if different than above)		City	State	ZIP Code	County
Type of Organization: supporting wage/tax documentation required. See Step 5 for list. <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other				Federal Tax ID Number	

Contact Information

Primary Contact Name/Title (Authorized Signatory)	Primary Contact Phone Number	Primary Contact Email
Billing Contact Name/Title (if different than above)	Billing Contact Phone Number	Billing Contact Email
Benefits/HR Contact Name/Title (if different than above)	Benefits/HR Contact Phone Number	Benefits/HR Contact Email

Eligibility Information

Total Number of Employees	Total Number of Full-time Employees	Total Number of Part-Time/Seasonal Employees
Total Number of Eligible Employees, Incl. Waivers	Total Number of Employees in Waiting Period	Benefit Eligibility Hours <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40
Waiting Period for New Employees to Obtain Health Insurance Coverage. 1st Day of the Month Following (Select One): <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 Days from Date of Hire <input type="checkbox"/> 60 Days from Date of Hire		Waive New-Hire Waiting Period During Initial Open Enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No

Employer Contribution: 50% contribution of the employee's premium is the minimum required for groups. Contribution requirements must also be met at the time of renewal.

Employer contributes ___% of the Employee Only Monthly Premium Amount	Employer contributes __% of the Dependent Monthly Premium Amount
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Current Carrier Name, if Applicable: _____

COBRA: Most group health plans with 20 or more employees on more than 50% of its typical business days are subject to COBRA. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

Is Employer Eligible for Federal COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you answered, "yes," please provide the Name and Address of your COBRA Administrator:
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Producer Information

Producer Name	Phone Number	Email
Agency Name	Agency Address	
Producer Signature	Date of Signature	

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STEP 2: PLAN SELECTION Employer may choose up to two (2) benefit plans. However, each family unit (e.g., employee, spouse/partner, and/or any dependent children) must be enrolled on the same benefit plan).

SMALL GROUP PLANS		LARGE GROUP PLANS <small>(Channel Manager: Attach THNM Large GNF and UW Rate Sheet)</small>				
Tue Preferred PPO Plans	<input type="checkbox"/> Platinum <input type="checkbox"/> Gold A <input type="checkbox"/> Gold B <input type="checkbox"/> Silver	1. _____ 2. _____				
True Select HMO Plans	<input type="checkbox"/> Platinum <input type="checkbox"/> Gold A <input type="checkbox"/> Gold B <input type="checkbox"/> Gold C <input type="checkbox"/> Silver A <input type="checkbox"/> Silver B <input type="checkbox"/> Silver C <input type="checkbox"/> Silver D <input type="checkbox"/> Silver E HDHP <input type="checkbox"/> Bronze A <input type="checkbox"/> Bronze B HDHP	<i>For THNM Use</i>	<i>Date</i>	<i>Reviewed by</i>		
		<i>Subs.</i>		<i>Deps.</i>	<i>Total Members</i>	
		<i>Binder</i> <input type="checkbox"/> Check <input type="checkbox"/> ACH		<i>Ongoing ACH?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		
		<i>SUTA?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>Other (see Sec. 5)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		
		<i>Notes</i>				

STEP 3: PAYMENT INFORMATION Employer group must submit the initial/binder premium payment with this application. Coverage will not go into effect until the first month's payment is received and confirmed by True Health New Mexico. Non-payment of premium will result in termination of policy.

How will your company pay the initial/binder premium payment?

- Paper Check:** Submit the initial/binder premium payment (payable to True Health New Mexico) with this application.
- One-Time Bank Draft:** If you wish to pay ONLY your initial/binder premium payment electronically, please complete the Automated Clearing House (ACH) Debit Authorization section below and select BINDER PAYMENT ONLY. This is a one-time bank draft of your initial/binder premium payment.

How will your company pay future monthly premium?

- Check:** You will be billed monthly. Submit premium payments (payable to True Health New Mexico) with your monthly invoice.
- Ongoing Bank Draft:** If you wish to have your bank account automatically drafted each month, please complete the Automated Clearing House (ACH) Debit Authorization section below and select ONGOING MONTHLY PAYMENTS. The account will be drafted on the first business day of each month.

Would you like the convenience of paying both your binder payment and your ongoing monthly premium automatically?

- Binder payment and Ongoing Bank Draft:** If you wish to have BOTH the initial/binder premium payment and future premium payments drafted each month, please complete the Automated Clearing House (ACH) Debit Authorization section below and select BOTH BINDER PAYMENT AND ONGOING MONTHLY PREMIUM. The account will be drafted on the first business day of each month.

Automated Clearing House (ACH) Debit Authorization

I hereby authorize True Health New Mexico to initiate debit entries and adjustments for any credits in error to the checking or savings account indicated below and request the financial institution named below to credit and/or debit the same to such account. This information will be kept for ongoing payments and the account listed will be drafted for the monthly premium amount. I am an authorized signor on the account indicated below.

Authorized Signor on Account (please print)	Title
Authorized Signature	Date

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Account will be drafted on the first business day of the month. Please select ONE draft option below.

<input type="checkbox"/> Binder Payment Only: One-Time Bank Draft for Initial/Binder Premium Payment ONLY	<input type="checkbox"/> Ongoing Monthly Payments Only: Ongoing Draft for Automatic Payment of the Monthly Premium ONLY	<input type="checkbox"/> Both (Binder Payment and Ongoing Monthly Payments): One-Time Draft for Initial/Binder Premium Payment AND Ongoing Drafts for Automatic Payment of the Monthly Premium
Name of Financial Institution		Address of Financial Institution
Name of Account/Name on Account		Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Financial Institution Transit Routing Number (9 digits)		Account Number

This authorization will remain in effect until True Health New Mexico has received written notification of its termination in such time and in such manner as to afford True Health New Mexico a reasonable opportunity to act on it.

STEP 4: READ AND SIGN

The undersigned Employer applies for the health care coverage as set out in this Employer Application and agrees to pay the required premium and to be bound by the terms and conditions of the contract. State and federal law guarantee renewability of small groups. It is understood that the benefits and rates quoted may change based on the actual enrollment of the group. The Employer agrees that an employee participation level when applicable must be maintained according to New Mexico laws and regulations and True Health New Mexico policies.

Employer acknowledges that if True Health New Mexico accepts this application and issues a Policy, True Health New Mexico may pay the Broker a commission and/or other compensation in connection with the issuance of such Policy. The undersigned further acknowledges that if additional information is needed regarding any commissions or other compensation paid the Broker by True Health New Mexico in connection with the issuance of a Policy, they should contact the Broker.

Employer represents and agrees that the information contained in this Application is true and correct and forms an essential basis for our issuance of the Contract. Even though this Application is submitted with proposed premiums or other funds, there will be no coverage until this Application is approved by True Health New Mexico. If True Health New Mexico approves this application, we will notify you and specify the effective date of group coverage. If we do not approve this Application, the submitted funds will be returned to the Employer.

Employer's Signature	Date
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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 5: REQUIRED SUPPORTING DOCUMENTATION

1. Employer Application, signed and completed; and
2. Employee Applications, signed and completed; and
3. First month's premium payment; and
4. Most recently filed quarterly state wage and tax report (State Unemployment Taxation Assessment [SUTA]).
 - Include status of all employees listed (specify if eligible, part-time, seasonal, in waiting period, or waiving). Each applicant must be accounted for in the supporting documentation.

If the group does not file a SUTA, or has not yet had to file a SUTA (e.g., a newly formed organization), the group must provide the following:

1. A copy of the current New Mexico Business License; and
2. An employer-signed, complete list of all employees on company letterhead, including status of all employees listed (e.g., eligible, part-time, seasonal, in waiting period, or waiving); and
3. **ONE** proof of business documentation as specified below:
 - Limited Liability Company – Articles of Incorporation/Organization; or
 - C Corporation – Form 1120, Form 941, Schedule E, Articles of Incorporation/Organization; or
 - S Corporation – Form 1120S, Schedule K-1, Form 941 (if there are employees in addition of shareholders), articles of incorporation/ organization, payroll records; or

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- Partnership – Form 1065 or Schedule K-1 for each partner; or
- Sole Proprietorship – Form 1040, Schedule C; or
- Non-Profit Organization – Form 941, W-2s, or 990.

STEP 6: IMPORTANT DEADLINES AND EFFECTIVE DATES

Submit completed Employer Application and supporting documentation to sales@truehealthnewmexico.org or upload to our agent portal, truehealthnewmexico.com/my-account-login.aspx. You may also submit paperwork directly to your True Health New Mexico account executive.

1. Submit completed documentation by the 15th of the month prior to the requested effective date to secure the requested coverage effective date.
2. Documentation received after the 15th of the month prior to the requested effective date will require a signed delay-of-service acknowledgement (see below).
3. Required documentation received after the 25th of the month will result in the requested effective date being moved to the next available effective date.
4. You may also call the True Health New Mexico Sales line for help at 1-855-808-3568. Select option 4 (brokers), then option 1 for a directory of sales executives.

Submit Online	Submit by Email*	Submit by Fax	Submit by Mail
truehealthnewmexico.com/my-account-login.aspx The most efficient method to enroll a group is to log in to the True Health New Mexico agent portal and complete enrollment electronically.	sales@truehealthnewmexico.com	1-800-734-1596	True Health New Mexico P.O. Box 36719 Albuquerque, NM 87176

*To protect the security of personal information, please ensure that you are sending information using secure (encrypted) email. If you cannot send secure email, please create an account in the True Health New Mexico Secure Messaging Portal, which can be found at truehealthnewmexico.com/my-account-login.aspx.

Delay of Service (DOS) Acknowledgement

Sold-case documentation received after the 15th of the month prior to the requested effective date will require a signed delay-of-service acknowledgement.

Thank you for choosing True Health New Mexico for your employees' healthcare coverage. Our goal is to provide the very best service and healthcare experience possible. Your Agent of Record is working with True Health New Mexico to secure the supporting documentation required to finalize your Employer Group Plan. Sold-case documentation received after the 15th of the month prior to the requested effective date will require a signed delay-of-service acknowledgement.

Given the very short period until your requested effective date of coverage, you and your employees may experience some delays in obtaining services during the initial period of coverage. Services may be disrupted or delayed as follows:

1. **Member identification numbers** and health plan identification cards may be delayed. Member identification numbers and identification cards will be available approximately 10 to 14 days after the sale has been finalized. Our Customer Service center may be unable to identify you during this period. Many physicians and other providers require the ID card at the time of service.
2. **Prescription eligibility** may be delayed. For example, if a member attempts to fill a prescription at a participating pharmacy, the member may be required to pay for the covered medications and seek reimbursement directly from the health plan. On occasion, participating pharmacies will reimburse the member the cost of the covered medication (minus the applicable copayment) if the member returns to the pharmacy within 5 days of the purchase and presents a valid identification number.
3. **Employee communications** may be delayed.
4. **Initial premium billing** may be inaccurate or delayed.

By signing below, the employer acknowledges the probability of service disruptions/delays. Please advise all enrolling employees, prior to the requested coverage start date, of probable service delays which may affect enrolling employees and/or covered dependents.

Employer's Signature	Date
Agent's Signature	Date