BeWell New Mexico's Health Insurance Marketplace

Application for Health Coverage & Financial Assistance

Apply faster online at enroll.bewellnm.com

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid (Medical Assistance)
- Certain income levels may qualify for free or low-cost programs.

Who can use this application?

- Use this application for anyone in your household.
- Apply even if you, your spouse or your child have health coverage. You may be eligible for free or lower-cost coverage.
- Households that include lawfully present 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 the attached appendix.

What you may need to apply

- Your Social Security Number (or document number if you're a lawfully present immigrant).
- Employer and income information for everyone in the household (for example, 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 Policy, visit **https://bewellnm.com/privacy-policy/.**

What happens next?

Send your complete, signed application to:

BeWell
PO BOX 25086
Albuquerque, NM 87125

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 receive a call from BeWell if we need more information. You'll get an eligibility determination letter in the mail after your application is processed. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** enroll.bewellnm.com
- **Phone:** Call BeWell Customer Service at 833-862-3935. TTY 711.
- **In person**: There may be BeWell Certified Assisters in your area who can help. Visit enroll.bewellnm.com or call BeWell Customer Service at 833-862-3935 for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al 833-862-3935.
- **Other languages:** If you need help in a language other than English, call 833-862-3935 and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit **https://bewellnm.com/nondiscrimination-and-accessibility/** or call the BeWell Customer Service Center at 833-862-3935 for more information. TTY 711

Please visit **https://bewellnm.com/privacy-policy/** for information about our Privacy Policy and Non-Discrimination Policy.

Privacy of Your Information
The privacy of your information is our top priority. We will keep your information private as required by federal and state law. Your answers on this form will only be used to determine eligibility for health coverage. We will verify your answers using the information in our electronic databases and the databases of federal and state agencies. If the information does not match, we may ask you to send us additional documentation. We will not ask any questions about your medical history. If you have questions about a request for information or suspect that the request is not from us, please contact our call center.

Important:
As part of the application process, we may need to retrieve your information from the Social Security Administration, the Department of Homeland Security, the Internal Revenue Service, a consumer reporting agency, and/or other services available through other federal agencies. We need this information to check your ability to enroll in coverage. After your initial application, we may also periodically check the information received against these sources to make sure it is up to date. If we find that your information has changed, we will notify you with a request to verify or update your information.

Primary Contact Name

First Name	Middle Name	Last Name	Suffix

Date of Birth

Primary Contact Home Address

Address 1

Address 2

City | State | ZIP Code

Current Living Arrangement (Select the one that best describes you)

- ☐ Substance Abuse Treatment Center
- ☐ Home for the aged
- ☐ Public Institution
- ☐ Homeless
- ☐ Temporarily living with friend or relative
- ☐ Homeless Shelter
- ☐ Group Living Arrangement
- ☐ At home
- ☐ Domestic Violence Shelter
- ☐ District of Columbia
- ☐ Facility
- ☐ Licensed foster family home or group home
- ☐ Boarding Arrangement
- ☐ Foster Care
- ☐ Halfway house
- ☐ House Arrest
- ☐ Prison
- ☐ Jail
- ☐ Job Corps
- ☐ College Housing

Primary Contact Mailing Address

☐ *Check if same as Primary Contact Home Address*

Address 1

Address 2

City | State | ZIP Code

Primary Contact Information

Email Address

Mobile Phone Number - -

Home Phone Number - -

Work Phone Number - - x

☐ *By checking this box, I consent to receiving phone calls and text messages. I understand that data rates and fees from my telephone provider may apply.*

Your phone number helps us keep your account secure. Your phone number may be used to deliver a secure code to verify your identity in certain special circumstances. Please provide a number where you can be reached if we need additional information or if we need to contact you about your enrollment.

Preferred method of communication:

☐ *Go Paperless (specify email)*

☐ *Postal Mail*

How would you like to receive your 1095-A form?

☐ *Go Paperless (specify email)*

☐ *Postal Mail*

Preferred Language for Communications

Preferred Spoken Language	☐ *English*	☐ *Spanish*	☐ *Other:*	
Preferred Written Language	☐ *English*	☐ *Spanish*	☐ *Other:*	

The primary applicant is the individual who is the primary person applying for insurance. The primary applicant should answer all of questions on pages 3-5 about themselves first. Use subsequent pages to answer the questions for other family members.

Primary Applicant Information

In this section, we will ask for more detailed information on the primary applicant. Following this section, we will ask for more detailed information about everyone in your household.

Primary Applicant

First Name | Middle Name | Last Name | Suffix

Date of Birth / /

Sex

Social Security Number

Please provide the applicant's Social Security Number (SSN) if they have one. If no SSN is provided, the applicant will be required to provide additional documentation at the end of the application, and may risk losing eligibility for coverage. Providing a SSN can help verify your eligibility to enroll in health coverage. If the applicant does not have a SSN, please visit www.ssa.gov/ssnumber to apply. If this person does not have a Social Security Number, please leave this blank and see the section below to provide further information.

Is the name you provided the same on this person's Social Security card? ☐ *Yes* ☐ *No*

If no, please enter the name as shown on the Social Security card.

Citizenship or Immigration Status

Is the applicant a U.S. citizen or U.S. national? ☐ *Yes* ☐ *No*

Is the applicant a naturalized citizen? ☐ *Yes* ☐ *No*

If the applicant is not a U.S. citizen or national, do you have an eligible immigration status? ☐ *Yes* ☐ *No*

Immigration Document Type | Status Type (Optional)

Write your name as shown on your immigration document.

Alien Registration or I-94 Number

Permanent Resident Card or Foreign Passport Number

SEVIS ID or expiration date (optional)

Other (category code or country of issuance)

Does the applicant also have any of these documents? (Select all that apply)

- ☐ *Certification from U.S. Department of Health and Human Services (HHS) Certificate from the Office of Refugee Resettlement*
- ☐ *Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)*
- ☐ *Cuban/Haitian Entrant*
- ☐ *Resident of American Samoa*
- ☐ *Battered spouse, child or parent under Violence Against Women Act*
- ☐ *Document indicating member of federally recognized Indian tribe or American Indian born in Canada*
- ☐ *Document indicating withholding of removal*
- ☐ *None of these*

Has the applicant had primary residence in the U.S. since 1996? ☐ *Yes* ☐ *No*

Help Paying for Coverage

Do you want to find out if you can get help paying for health coverage? ☐ *Yes* ☐ *No*

If you indicate you do not want help paying for coverage, you will not need to provide financial information and can skip the Income Information section. However, you will not be considered for subsidies that could lower your cost of health insurance. You will be applying for full-cost insurance.

Income Information

Please complete income information for each individual applying. We ask for current information for everyone in your household to make sure you get the most benefits possible. Before you start, please take a moment to gather the information listed below. You may need:

- Pay Stubs
- W-2 Forms

Note: We do not need to know about income from child support, veterans payments or supplemental security income

Following income information is based off which family or household member?

Forms of income (Check all that apply)

☐ *Job*	Amount	Frequency
	Name of employer	
☐ *Pension*	Amount	Frequency
☐ *Rental or Royalty*	Amount	Frequency
☐ *Alimony Received*	Amount	Frequency
☐ *Scholarship*	Amount	Frequency
☐ *Self-Employment*	Amount	Frequency
☐ *Social Security Benefits*	Amount	Frequency
☐ *Farming or Fishing*	Amount	Frequency
☐ *Investment*	Amount	Frequency
☐ *Retirement*	Amount	Frequency
☐ *Capital Gains*	Amount	Frequency
☐ *Unemployment*	Amount	Frequency
☐ *Other Income*	Amount	Frequency

Deductions

Telling us about the things that can be deducted on an income tax return could lower the cost of your health insurance.

Does the applicant pay any of these deductions?

- ☐ *Alimony* $
  (Only include alimony as income if the divorce or separation was finalized before January 1, 2019.)
- ☐ *Student loan interest* $
- ☐ *Certain Business expenses for reservists, performing artists, and fee based government officials* $
- ☐ *Health Savings Account (HSA) deposits (in limited situations)* $
- ☐ *If self-employed, subtract your tax-deductible expenses when you figure out your net self-employment to enter on your application* $
- ☐ *Simplified Employee Pension, SIMPLE IRA, and qualified retirement plans* $
- ☐ *Self-employed health insurance deduction* $
- ☐ *Early savings withdrawal penalty* $
- ☐ *IRA contributions (if you don't have a retirement account through a job* $
- ☐ *Moving expenses* $
- ☐ *Educator expenses (If you're a teacher and pay for supplies out-of-pocket)* $
- ☐ *Other Deductions* $

About Your Household

In this section, we will ask for more detailed information about everyone in your household. If more than two applicants are applying in addition to the primary applicant, please print extra copies of one of these sections to include with the completed paper application. The primary applicant should use Pages 3-5 to answer these questions about themselves, and then use subsequent pages to answer the questions for each additional family member.

Family Member

First Name | Middle Name | Last Name | Suffix

Date of Birth / / Sex

How is this person related to the Primary Applicant?

- ☐ *Brother-in-law or Sister-in-law*
- ☐ *Child (son or daughter)*
- ☐ *Court Appointed or Live-in Guardian*
- ☐ *Domestic Partner*
- ☐ *First Cousin*
- ☐ *Former Spouse*
- ☐ *Grandchild*
- ☐ *Grandparent*
- ☐ *Mother-in-law or Father-in-law*
- ☐ *Nephew or Niece*
- ☐ *Parent (Mother or Father)*
- ☐ *Sibling (Brother or Sister)*
- ☐ *Son-in-law or Daughter-in-law*
- ☐ *Spouse*
- ☐ *Stepchild*
- ☐ *Stepparent*
- ☐ *Uncle or Aunt*
- ☐ *Ward*
- ☐ *Unrelated*

Does this person live at an address other than the Primary Applicant's address? ☐ *Yes* ☐ *No*

If no, provide their address below:

Address 1

Address 2

City | State | ZIP Code

Social Security Number

Please provide the applicant's Social Security Number (SSN) if they have one. If no SSN is provided, the applicant will be required to provide additional documentation at the end of the application, and may risk losing eligibility for coverage. Providing a SSN can help verify your eligibility to enroll in health coverage. If the applicant does not have a SSN, please visit www.ssa.gov/ssnumber to apply. If this person does not have a Social Security Number, please leave this blank and see the section below to provide further information.

Is the name you provided the same on this person's Social Security card? ☐ *Yes* ☐ *No*

If no, please enter the name as shown on the Social Security card.

Citizenship or Immigration Status

Is the applicant a U.S. citizen or U.S. national? ☐ *Yes* ☐ *No*

Is the applicant a naturalized citizen? ☐ *Yes* ☐ *No*

If the applicant is not a U.S. citizen or national, do you have an eligible immigration status? ☐ *Yes* ☐ *No*

Immigration Document Type

Status Type (Optional)

Write your name as shown on your immigration document.

Alien Registration or I-94 Number

Permanent Resident Card or Foreign Passport Number

SEVIS ID or expiration date (optional)

Other (category code or country of issuance)

Does the applicant also have any of these documents? (Select all that apply)

☐ *Certification from U.S. Department of Health and Human Services (HHS)*
☐ *Certificate from the Office of Refugee Resettlement*
☐ *Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)*
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☐ *Resident of American Samoa*
☐ *Battered spouse, child or parent under Violence Against Women Act*
☐ *Document indicating member of federally recognized Indian tribe or American Indian born in Canada*
☐ *Document indicating withholding of removal*
☐ *None of these*

Has the applicant had primary residence in the U.S. since 1996? ☐ *Yes* ☐ *No*

Help Paying for Coverage

Do you want to find out if you can get help paying for health coverage? ☐ *Yes* ☐ *No*

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Please complete income information for each individual applying. We ask for current information for everyone in your family and household to make sure you get the most benefits possible. Before you start, please take a moment to gather the information listed below. You may need:

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☐ *Investment*	Amount	Frequency
☐ *Retirement*	Amount	Frequency
☐ *Capital Gains*	Amount	Frequency
☐ *Unemployment*	Amount	Frequency
☐ *Other Income*	Amount	Frequency

Is any of your income from these sources?

☐ *Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties.*
☐ *Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian land by the Department of the Interior (including reservations and former reservations).*
☐ *Money from selling things that have cultural significance.*

Expected Income Information

Based on what you know today, how much do you think you will make in 2026? If you don't know, that's OK. Make your best estimate.

Total Yearly Amount

Deductions

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☐ *Social Security Benefits*	Amount	Frequency
☐ *Farming or Fishing*	Amount	Frequency
☐ *Investment*	Amount	Frequency
☐ *Retirement*	Amount	Frequency
☐ *Capital Gains*	Amount	Frequency
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- ☐ *If self-employed, subtract your tax-deductible expenses when you figure out your net self-employment to enter on your application* $
- ☐ *Simplified Employee Pension, SIMPLE IRA, and qualified retirement plans* $
- ☐ *Self-employed health insurance deduction* $
- ☐ *Early savings withdrawal penalty* $
- ☐ *IRA contributions (if you don't have a retirement account through a job* $
- ☐ *Moving expenses* $
- ☐ *Educator expenses (If you're a teacher and pay for supplies out-of-pocket)* $
- ☐ *Other Deductions* $

Household Information

Military Service

Are any members of your household an honorably discharged veteran or active duty member of the military? If yes, ☐ ☐

please provide the name of the person:

Tax Information

Who plans to file a federal income tax return for 2025?

(If married): Do you plan on filing a joint federal income tax return for 2025?

Please indicate which of the tax filers should be considered the primary applicant for this application (if filing joint return, this is the Primary Tax Filer)

Who are the dependents who will be claimed by the tax filer(s) on their income tax return?

American Indian/Alaska Native

Are any of the members of your household American Indian/Alaska Natives? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

State

Tribe Name

Is the tribe federally recognized? ☐ *Yes* ☐ *No*

Is the applicant eligible to get health services from the Indian Health Service, a tribal health program or an urban Indian health program, or through referral from one of these programs? ☐ *Yes* ☐ *No*

Has the applicant ever gotten a health 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*

Medicaid Information

Was anyone on this application have Medicaid that will end soon or that recently ended? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

What's the last day of Medicaid Coverage?

Has the household income or household size changed since applicant was told their coverage was ending? ☐ *Yes* ☐ *No*

Was anyone on this application found ineligible for Medicaid in the past 90 days? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

When was the applicant denied Medicaid coverage?

Pregnancy Information

Any of the members of your household pregnant or were they pregnant in the last 12 months? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

How many babies are expected in this pregnancy?

Disability Information

Do any of the members of your household have a physical disability or mental health condition that limits their ability to work, attend school or take care of their daily needs? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

Do any of the members of your household need help with activities of daily living (such as bathing, dressing and using the bathroom), or live in a nursing home or other medical facility? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

Student Information

Are any of the members of your household full-time students? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

Foster Information

Were any of the members of your household ever in foster care? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

In what state(s) was/were this/these applicant(s) in the foster care system?

Was/were this/these applicant(s) getting health care through Medicaid? ☐ *Yes* ☐ *No*

How old was/were the applicant(s) when he/she/they left the foster care system?

Additional Information

Other Coverage

Are any applicants currently enrolled in health coverage that will extend beyond 60 days from today? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

If yes, what type of coverage does the applicant have?

**Don't check the Medicaid box if one of these applies to your coverage: 1) Your coverage pays for only limited benefits, such as family planning services, emergency services, outpatient hospital services or treatment of tuberculosis. 2) Your Medicaid coverage doesn't pay for inpatient hospital services.*

- ☐ *Medicaid*
- ☐ *COBRA Coverage*
- ☐ *Marketplace*
- ☐ *Medicare*
- ☐ *Peace Corps*
- ☐ *Retiree Health Benefits*
- ☐ *TRICARE*
- ☐ *Veterans Affairs (VA) Health Care Program*
- ☐ *Marketplace Coverage*
- ☐ *Other Coverage*

Insurance Name (Optional)

Policy Number (Optional)

Is this a limited benefit coverage? ☐ *Yes* ☐ *No*

Reconciliation of Advanced Premium Tax Credits

In the years you received Advance Premium Tax Credits (APTC), did you file a federal income tax return and reconcile any APTC you used?

NOTE: Check Yes only if ALL of these apply to you:

- *You used advance premium tax credits in one or more past years to lower your costs of Marketplace coverage.*
- *You filed a federal income tax return each of these years.*
- *The tax filer(s) submitted IRS Form 8962 with the tax return.*

☐ *Yes* ☐ *No* ☐ *I have not received APTC*

Employer Coverage Details

Will the applicant be offered health coverage through a job (including another person's job, such as a spouse or parent)? ☐ *Yes* ☐ *No*

Employer Name

Employer Phone Number

Employers Address

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

☐ *Yes:* ☐ *No*

What is the premium amount for the lowest-cost plan available to this applicant that meets the minimum value standard?

Health Reimbursement Arrangement Detail

Has the applicant been offered health coverage through a job (including another person's job, such as a spouse or parent)? ☐ Yes ☐ No

What kind of HRA is being offered? (Select one that apply)

- ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)
- ☐ Qualified Small Employer Health Reimbursement Arrangement (QSHERA)

What is the maximum monthly reimbursement amount for your HRA offer(s)? $

When will your HRA coverage begin?

Additional Information

Would the applicant like help paying for medical bills from the last 3 months? ☐ Yes ☐ No

If applicant is eligible for Medicaid, which Managed Care Organization would they like? (Select one)

☐ Presbyterian
☐ Blue Cross Blue Shield
☐ Molina
☐ United HealthCare

Are any applicants incarcerated in a jail, prison, detention facility or other correctional housing? ☐ Yes ☐ No

If yes, please provide the name of the person:

Are any of the incarcerated persons awaiting disposition of their charges? ☐ Yes ☐ No

If yes, please provide the name of the person:

Optional Questions

These questions are optional, and you do not need to answer them to apply for health insurance. If you choose to answer them, BeWell will use this information to get a better understanding of the demographics and health needs of New Mexicans. This information will also be shared with the US Department of Health and Human Services to support a broader understanding of health needs across the U.S.

Hispanic/Latino Ethnicity ☐ *Yes* ☐ *No*

Race (check all that apply):

- ☐ *American Indian or Alaska Native*
- ☐ *Asian Indian*
- ☐ *Black or African American*
- ☐ *Chinese*
- ☐ *Filipino*
- ☐ *Guamanian or Chamorro*
- ☐ *Japanese*
- ☐ *Korean*
- ☐ *Native Hawaiian*
- ☐ *Other Asian*
- ☐ *Other Pacific Islander*
- ☐ *Samoan*
- ☐ *Vietnamese*
- ☐ *White or Caucasian*
- ☐ *Other*

Marital Status

Is the applicant married? ☐ *Yes* ☐ *No*

Who is the applicant's spouse?

- ☐ *Someone already on the application*
- ☐ *Someone else who isn't applying for health coverage*

Parent/Caretaker Information

Is the applicant the main person taking care of any of the children named in the About Your Household section? ☐ *Yes* ☐ *No*

Permissions and Sign

Please review the information below and fill out the boxes provided before signing.

Consent for Renewal
To make it easier to reduce the cost of my health insurance coverage in future years, I agree to allow BeWell to use computer sources, such as the Internal Revenue Service (IRS), to check my income. I also agree to allow BeWell to use my income data, including information from my tax returns, to determine whether I am eligible to continue to receive financial assistance. If those sources show I am still eligible for continued financial assistance, my insurance coverage and financial assistance will be renewed for another 12 months. I understand BeWell will send me a notice explaining that I have been renewed in coverage and allow me to make any changes necessary. I acknowledge if I elect not to give this consent, my insurance will be renewed without financial assistance for the following year. I also acknowledge I can discontinue, change, or otherwise opt out at any time.

Yes, allow BeWell to check my information and use it for: (Select one that applies)

- ☐ *5 years (the maximum number of years allowed)*
- ☐ *4 years*
- ☐ *3 years*
- ☐ *2 years*
- ☐ *1 year*
- ☐ *No, I do not give BeWell consent to use my income data at renewal.*

State Out Of Pocket Assistance Consent
If I am enrolled in a Turquoise Plan and I report a change in my household's income, I consent to being automatically re-enrolled into a similar plan with different cost-sharing reductions.

I understand that if I consent to being automatically re-enrolled, my cost-sharing reductions may change, including (but not limited to) my deductible, copays, and coinsurance amounts, and I can opt out of automatic re-enrollment.

- ☐ *I consent to automatic re-enrollment*
- ☐ *I do not consent to automatic re-enrollment*

Change Report Agreement
I understand I have 30 days to notify the BeWell of any change of information in this application. I will report any changes within this time period. I understand changes in my household size address, income, or other details might affect my or my household's eligibility for specific benefits. I understand and will notify BeWell if my application information changes.

Medicaid Cooperation
By providing my eSignature, I consent to my information being shared with the New Mexico Health Care Authority for the purposes of making a Medicaid eligibility determination if my application fits specific criteria to be potentially eligible or if I otherwise request a Medicaid determination directly.

Medicaid Estate Recovery
By providing my eSignature below, I am giving the New Mexico Health Care Authority, administrators of Medicaid, the right to pursue and get any money from other health insurance, legal settlements, or other third parties should someone on this application enroll in Medicaid. I am also giving the New Mexico Health Care Authority, as the Medicaid agency, the right to pursue and get medical support from a spouse or parent.

True and Correct Acknowledgement
I also attest the information provided in this application, at the time it was submitted, was true and correct to the best of my knowledge.

Penalty of Perjury Acknowledgement
By providing my eSignature, I am signing this application and affirming the accuracy of the information provided and any assertions made herein, under penalty of perjury, pursuant to 28 U.S.C. § 1749 and NMSA 1978 § 59A-16-23. I acknowledge that I may be subject to penalties under federal and state law if I intentionally provide false information. Additionally, I acknowledge that typing my name in the box below constitutes my signature.

Signature of PRIMARY APPLICANT

Date Signed (mm/dd/yyyy)

Appendix: Appoint an Authorized Representative

You have the right to choose an authorized representative to help you. This is a trusted person who has your permission to talk about your application with BeWell, see your information, and act for you on matters related to your application, including receiving information about you and signing documents on your behalf. If you want to appoint an authorized representative, you must complete and submit this form. **Your authorized representative can be an attorney but does not have to be.**

Please Note: Your authorized representative will be able to sign your application as if they were you, submit updates and respond to eligibility redeterminations for you, as well as receive copies of your notices and other communications from BeWell. In addition, your authorized representative can act on your behalf in all other matters before BeWell **until you rescind this appointment (or it expires). If you ever need to change your authorized representative, including removing your authorized representative, please contact BeWell customer service center at 833-862-3935.**

If you are a legally appointed authorized representative for someone, please submit proof with this application.

Make a copy for your records and mail the completed form to: **BeWell, PO Box 25086, Albuquerque, NM 87125**

You may also fax the form to a secure fax line: **833-862-3935.**

Step 1: Enter information for the customer who is appointing a representative.

First Name | Middle Name | Last Name | Suffix

Date of Birth / / | Email Address

Mailing Address | Apartment or Suite Number

City | State | ZIP Code

BeWell Account # (if you have one)

Step 2: Enter information for the authorized representative.

By appointing an authorized representative, you are requesting that BeWell send all communications to your representative.

Auth. Rep.'s First Name | Middle Name | Last Name | Suffix

Date of Birth / / | Email Address

Mailing Address | Apartment or Suite Number

City | State | ZIP Code

Daytime Phone Number - -

Organization Name (if applicable) | Title (if applicable)

Step 3: Customer Signature

By signing below, the undersigned hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1749 and NMSA 1978 § 59A-16-23, that the above information in this form is true and correct based on their personal knowledge and that the undersigned hereby allows the person named in Step 2 to serve as their authorized representative. By signing this form, the undersigned hereby empowers their authorized representative to act on their behalf with respect to any part of their application until the authorization is otherwise rescinded or it expires.

☐ Up to: / / Date (mm/dd/yyyy)

☐ Until I, the applicant, indicate that the representative is no longer authorized to act on my behalf.

Printed Name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)
/ /

Step 4: Authorized Representative Signature (other than Brokers, Enrollment Counselor's or Assisters)[1]

By signing below, the undersigned agrees to serve as the authorized representative for the person named in Step 1. The undersigned agrees to be responsible for fulfilling all responsibilities of an authorized representative. Furthermore, the undersigned agrees to maintain and be legally bound to maintain the confidentiality of any information regarding the applicant or enrollee provided by the exchange in accordance with federal and state law. By signing below, the undersigned hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1749 and NMSA 1978 § 59A-16-23, that the information in this form is true and correct based on his or her personal knowledge and they agree to the terms outlined herein.

Printed Name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)
/ /

[1] Brokers, Enrollment Counselor's or Assisters have already executed a Non-Exchange Entity agreement that includes these terms and conditions. As a result, their signature is not required. Brokers, Enrollment Counselor's and Assisters can sign this form if they chose to do so.