Small Business Health Options Program (SHOP)

Health Coverage Application for Employers

SHOP is open to all eligible small business owners. It should take about 15 minutes to complete this eligibility application.

Things To Know

Is My Business Eligible for SHOP?	To be eligible, your business or organization must meet all the following criteria: • Have a primary business address in the state of New Mexico • Have at least have two Full-time equivalent (FTE), non-owner employees. • Have 50 or fewer FTE employees • Offer coverage through SHOP to all FTE employees
Get Help	• Contact an agent or broker by clicking on Find help near you • Phone: Call 1-833-862-3935 Option # 8 For Small Business (SHOP) in both English or Spanish. • Email: Business@beWellnm.com
What Happens Next?	Email this completed form to Business@beWellnm.com or send it by U.S. mail to: ATTN: SHOP Eligibility New Mexico Health Insurance Exchange 7601 Jefferson Blvd NE. Suite 120 Albuquerque, NM 87109 You may also contact an insurance agent or broker to begin the application and enrollment process.

Shop Eligibility Form

Health Coverage Application for Employers

Step 1: Tell us about the employer offering coverage.

Employers must be located with the same state they are buying health coverage and must offer coverage to all full-time employees (those working on average 30 hours + per week).

Items with an asterisk (*) are required.

1. Employer Name*		
2. Federal Employer Identification Number (EIN)*		
3. Doing Business as (if applicable)		
4. Select the Type of Coverage being requested:	☐ Medical	☐ Dental
5. Primary Business Address*		
6. City *	7. State*	8. ZIP Code*

☐ I certify that this employer meets the following eligibility criteria:

Has a primary business address in New Mexico.
Has 2-50 full time employees that are non-owners.
Offers coverage to at minimum, all full-time employees.

Required documents needed from the employer to determine eligibility. This information is used to verify the business tax identification number and location.

- New Mexico ES90A Quarterly wage notice
- State Form WC-1
- Federal Form 941

Shop Eligibility Form

Step 2. Tell us who to contact about this application.

Primary Contact Information:

1. First Name*	Middle Name	Last Name*	Suffix
2. Title			
3. Mailing Address (if different than above)			
4. City*	5. State*	6. ZIP Code*	
7. Phone Number*	8. Additional Contact Number: ☐ Work ☐ Home ☐ Cell		
9. Fax Number			
10. Email Address*	Re-enter email address*		
11. Preferred Language (if not English)			

Step 3. For Agents and Brokers Only

Complete this section if you are and agent or broker filling out this application for an employer.

1.First name	Middle Name	Last Name	Suffix
2. Organization Name:		3. Agent National Producer Number (NPN)	
4. Phone Number: ☐ Work ☐ Home ☐ Cell		5. Second Phone Number: ☐ Work ☐ Home ☐ Cell	
6. Fax Number	7. Email address		Re-enter email address

Shop Eligibility Form

Health Coverage Application for Employers

Step 4. Read and Sign this Application

By signing this application, the undersigned employer understands, acknowledges, and certifies as follows:

1. I have a primary business address in New Mexico
2. I employ at least one enrolling employee who is not an owner or spouse of an owner.
3. I have from 2 to 50 full time equivalent employees
4. I am offering coverage to all full-time employees.
5. The information on this application will only be used to determine eligibility for health coverage and will be kept private as required by law. If my business or organization is eligible, this information will be used to facilitate enrollment.
6. I must tell the New Mexico Health Insurance Exchange if anything changes (or is different than) what I wrote on this application.
7. I have consent from everyone I'll list on the application to include their personally identifiable information, like dates of birth, Social Security numbers, addresses, and phone numbers.
8. Under state and federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability.
9. I can file a complaint of discrimination by visiting www.beWellnm.com or www.hhs.gov/ocr/office/file
10. I am signing this application under penalty of perjury, which means I've provided true and answers to all information to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information

Print Name of Person Signing:	
Signature*	Date (mm/dd/yy) *

Step 5. Mail the Application to:

Attention: SHOP Eligibility

New Mexico Health Insurance Exchange

7601 Jefferson Blvd NE, Suite 120

Albuquerque, NM 87109