NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

Employer Subgroup Information Page and Application Addendum

Billing subgroups are subject to approval by Delta Dental of New Mexico. Please use an additional Subgroup Information Page and Application Addendum if more than two subgroups are being requested.

☐ This addendum is hereby made a part of the Group Insurance Application applicable to the employer indicated below, for a billing subgroup to be effective per the Group's requested coverage Effective Date as of the first day of ____________________ , 20__________ .

☐ This addendum is hereby made a part of the Group Insurance Application applicable to the employer indicated below, for the addition of a billing subgroup(s) to the Group's in-force Delta Dental of New Mexico Group, #______________, for an Effective Date as of the first day of______________________, 20 __________.

Employer (Group) Name ____

Group Number __________________________

Subgroup #0002

Subgroup Name ____

Subgroup Number ____________________

Street Address__________________________________City ____________________State ______Zip_____________

Telephone (____) __________________Fax (____) ________________ Tax ID# ______________________________

Subgroup Contact____________________ Title _________________________E-Mail ___________________________

Billing Address (if different from employer's primary billing address) ____

Subgroup #0003

Subgroup Name ____

Subgroup Number ____________________

Street Address__________________________________City ____________________State ______Zip_____________

Telephone (___) ___________________Fax (___) __________________ Tax ID#______________________________

Subgroup Contact____________________ Title _________________________E-Mail ___________________________

Billing Address (if different from employer's primary billing address) ____

Employer Signature and Acknowledgment

I understand that subgroups are approved for billing convenience only; that the approval of a subgroup(s) does not create a different Premium due date(s) for any subgroup(s) under my primary Group number; and that coverage for my entire Group will be terminated for non-payment if Premium payment for any individual subgroup is not made on a timely basis.

Executed this day of ______________________ , 20 ________ .

Authorized Signature (Group)________________________________ **Title** ____

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.