HEALTH CARE AUTHORITY

State Employee Premium Assistance (DACA) Application Form

If you have any questions about DACA or completing this form, please contact EASI Gov, Inc. at 505-705-3310. Fax all forms and documentation to Fax: 1-505-705-3312 or email to DACA@easitpa.com

Applicant Information

Applicant Name (First, MI, Last)			Date of Birth (MM/DD/YYYY)	Sex

Email Address

Home Phone	Work Phone	Cell Phone

Physical Address / City / State / Zip / County

Mailing Address / City / State / Zip / County

DACA Approval

Are you currently a DACA recipient with valid approval?

Examples of acceptable proof: DACA Employment Authorization Document (Form I-766) and the most recent DACA approval notice from USCIS.

Tax and Income Information

Modified Adjusted Gross Annual Household Income (MAGI)	Household Size	Do you currently have income?
$		

Attach required proof of income (tax return, W-2/1099, pay stubs, etc.) with your submission.

Other Health Insurance Coverage

Do you have other health insurance coverage?	Insurance Provider Name	Policy Number

Broker Information

Did you use a broker?	Broker First Name	Broker Last Name	Broker ID

Enrollment Options (Optional)

Medical Plan (optional)

After eligibility is confirmed, you may select medical and dental plans. Review plan documents and provider directories.

Application Assistance

Assistant First Name	Assistant Last Name	I am legally authorized to represent the applicant

Rights, Responsibilities, and Legal Notices

By submitting this application, you affirm that the information provided is true and complete to the best of your knowledge. You understand your responsibility to report changes that may affect eligibility, including changes in income, household size, or other coverage.

DACA Program Plan Year 2026

Rights and Responsibilities & Appeals Statements

Any person who knowingly and with intent to defraud any insurance company or other person, files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime; Insurance Fraud will be prosecuted to the fullest extent of the law and may prohibit access to Health Care Authority Benefits in the future.

I understand that services will be available subject to exclusions, limitations, and conditions described in the summary plan descriptions (found on each carrier's website). I certify that the above information is correct to the best of my knowledge and belief.

The Health Care Authority and EASI Gov are required by Federal Law to maintain and protect the privacy of your health information and provide you with notice of its legal duties and privacy practices. The privacy notice is posted [Insert EASI Gov website link of posting of privacy policy]

Change Report Agreement:

I understand I have 30 days to notify EASI Gov of any change of information in this application. I will report any changes within this time period. I understand changes in my household income or other details might affect my eligibility for benefits. I understand and will notify EASI Gov customer service team if my application information changes at1-505-216-7800 or email at DACA@easitpa.com.

Penalty of Perjury Agreement:

By providing my e-signature, 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 I may be subject to penalties under federal and state law if I intentionally provide false information. Additionally, I acknowledge that signing my name in the box below constitutes my e-signature.

Right to Appeal:

If you do not agree with a decision made by EASI Gov on behalf of the Health Care Authority, you can file an appeal with EASI GOV within 90 days of the eligibility determination. If you disagree with the appeal decision made by EASI Gov, you can appeal directly to HCA within 30 days of the EASI Gov appeal decision.

Depending on your appeal, you may be able to maintain your eligibility for health insurance coverage and Premium Assistance while your appeal is processed.

If your health carrier denies your claim, contact them directly. If you cannot resolve the problem with your health insurance carrier, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI): https://www.osi.state.nm.us/en/complaints/ or 855-427-5674.

Questions:

To learn more about your appeal, contact the EASI Gov customer service team at 1-505-216-7800

Privacy Disclosure:

EASI Gov protects the privacy and security of the personal identifiable information (PII) that you have provided. The PII used to create this notice was collected from information you provided to EASI Gov. If you have questions about this data, contact us at 1-505-216-7800

Nondiscrimination and Accessibility:

The Health Care Authority does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of certain factors, including (but not limited to) health status, the need for health care services, race, color, national origin, gender, gender identity, age, disability, or sexual orientation. Auxiliary aids and services are available to individuals with disabilities. If you need these services, please contact EASI Gov at 1-505-216-7800 . If you think you have been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Superintendent of Insurance at: Office of Superintendent of Insurance | Managed Health Care Bureau | P.O. Box 1269 | Santa Fe, NM 87501 | Phone: 1-855-427-5674.

I have read and agree to the rights and responsibilities.

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Signature (Type full name) | Print Name | Date