PRESBYTERIAN
Health Plan, Inc.

Application for Individual & Family Plan

Get help with this application by contacting your broker directly or the Presbyterian Individual Plan Sales Team at 1-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users, please call 1-877-298-7407. TTY users please call: Relay 711 or 1-800-659-8331

SUBMIT BY FAX: 505-923-8252	**SUBMIT BY MAIL:** Presbyterian Health Plan P.O. Box 27489 Albuquerque, NM 87125-7489	**APPLY ONLINE:** www.phs.org/iPlanEnroll

APPLICATION INSTRUCTIONS

1. Apply faster online at www.phs.org/iPlanEnroll
2. Dependent children age 26 or older must apply separately for his or her own policy. When a covered dependent child turns 26, he or she can transfer to his or her own policy without reapplying. This transfer is good as long as the request to transfer is submitted within 31 days of the covered dependent's 26th birthday.
3. Your effective date depends on the date we receive your application.
   a. It is the first (1st) of the month if application is received by the fifteenth (15th) day of the month.
   b. It is the first (1st) of the **following** month if the application is received after the fifteenth (15th) day of the month.
   c. Please contact us to find out your effective date if you are enrolling because of a qualifying event, such as a loss of coverage.
4. Make a copy of your completed application for your records.

STEP 1 Tell us about yourself

(We'll need one adult in the family to be the contact person for your application.)

1. First Name, Middle name, Last name & Suffix

2. Physical Home address (required)		3. Apartment or Suite Number	
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (if different from home address)		9. Apartment or Suite Number	
10. City	11. State	12. ZIP Code	13. County
14. Preferred phone number ( ) -		15. Other phone number ( ) -	

16. Do you want to get plan information by email? ☐ Yes ☐ No
Email address:____

17. Social Security number ___ - __ - ____

18. Sex ☐ Male ☐ Female	19. Date of birth (mm/dd/yyyy)

20. Do **you** need health coverage? ☐ Yes ☐ No, child only coverage. Go to step 2

21. If Yes to question #20, Primary Care Provider Name:

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STEP 2 NOW, tell us who else needs health coverage.

(If you have more people to include, make a copy of this page and attach)

Name First Name, MI, Last Name	Relation (Spouse/Child)	Gender	DOB (mm/dd/yyyy)	SSN	Primary Care Provider Name
		M ☐ F ☐			
		M ☐ F ☐			
		M ☐ F ☐			
		M ☐ F ☐			
		M ☐ F ☐			

22. Are all applicants U.S. citizens or U.S. nationals? ☐ Yes ☐ No
23. If no, do you have eligible immigration status?

☐ Yes, fill in your document type and ID number ☐ No, you are not eligible for this plan

Applicant(s) Name____________________________ Immigration Document Type ____________________

Document ID Number ________________________

STEP 3 Effective Date Selection

Your effective date will be the first (1st) of the month if application is received by the fifteenth (15th) day of the month or the first (1st) of the following month if application is received after the fifteenth (15th) day of the month.

☐ Next Available

☐ Other ____________ within 60 days of your signature date for this application

Month

There are exceptions on effective dates for members enrolling due to a qualifying event such as loss of coverage. Please contact the plan to determine your effective date.

STEP 4 Tell us what plan you would like to choose

Individual Platinum Plan	Individual Gold Plans	Individual Silver Plans	Individual Bronze Plans	Individual Catastrophic Plan
☐ Platinum	☐ Gold A ☐ Gold B ☐ Gold C	☐ Silver A ☐ Silver B ☐ Silver C ☐ Silver D ☐ Silver E	☐ Bronze A ☐ Bronze B ☐ Bronze C	☐ Catastrophic Plan *for individuals under age 30 years.*

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STEP 5 Tell us how you will pay your monthly premiums

If you do not select a payment option, you will get a bill each month.

Please select one of the following options to make prepayments:

☐ Credit Card ☐ Automatic Bank Draft ☐ Get a bill

Credit / Debit Card

☐ MasterCard ☐ Visa ☐ Discover

Card Account # ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Name on Card____ Card Expiration Date _____/_____

Card Billing Address (address where you received your card statements)

Street Address____

City_______________________ State _________________ Zip _________________

Automatic Bank Draft

☐ Checking Account ☐ Savings Account

Name of Bank ____

Account Number _______________________Routing Number ________________

Name of Account Holder ____

STEP 6 Read & Sign this application

Presbyterian Health Plan, Inc. (PHP) insurance is prepaid health coverage. This means you pay your premium payment for coverage prior to the month of coverage. If you do not select a payment option, you will get a bill each month.

I hereby authorize and request PHP to initiate withdrawal entries from the account(s) and the financial institution(s) indicated above for the monthly premium payments required by the Subscriber Agreement. These withdrawals are for premium payments for the enrolled individuals listed in Step 1 and/or 2 of this application. This authorization is to remain in effect until PHP and/or the financial institution(s) named above are notified in writing.

I understand applicants enrolled for coverage shall be provided a ten-day period from the effective date of coverage to examine and return the contract and have the premium refunded. If medical services were received during the ten-day period, and the member returns the contract to receive a refund of the premium paid, he or she must pay for such services.

I understand covered benefits, services, utilization management procedures, exclusions, and limitations are subject to the provisions of the *Subscriber Agreement* and/or *Summary of Benefits Coverage*. These documents may be found at www.phs.org/FormsAndDocuments or you may contact Presbyterian Customer Service Center by phone at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users please call: Relay 711 or 1-800-659-8331

I understand this policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the New Mexico Health Insurance Exchange at www.nmhix.com if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

Read & Sign this application…Continued

I hereby authorize to the extent permitted by applicable law, the use or release of my protected health information (PHI) by any person or entity, without limitation including practitioners, providers, and insurance companies to PHP or its designees for any permitted purpose. Purposes including, but not limited to, evaluating my application for insurance, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment or healthcare operations activities of PHP. This consent shall not permit use or disclosure of PHI when authorization is required by law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. Notices of Privacy Practices can be found online at https://www.phs.org/Pages/privacy-security.aspx. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Presbyterian.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FORM FOR PAYMENT OF A LOSS OF 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. PRESBYTERIAN HEALTH PLAN, INC. MAY TERMINATE A MEMBER FOR ANY TYPE OF FRAUDULENT ACTIVITY.

I understand that upon enrollment, I will receive my Presbyterian Health Plan, Inc., Subscriber Agreement, which contains the benefits, limitations, and exclusions applicable to my healthcare plan.

I understand that I am entitled to a copy of this signed Application upon request.

I acknowledge (or Legal Guardian of Minor Dependent), that I have read and understand this Application in its entirety.

Signature x	Date (mm/dd/yyyy)*

*Application will expire within 60 days from the date of your signature.

For agents and brokers

Complete this section if you're an agent or broker filling out this application for somebody else.

1. First name, Middle name, Last name & Suffix	2. Phone Number
3. Organization name	4. ID number (if applicable)