

# Application for Individual & Family Plan

Get help with this application by contacting us at 1-866-869-7737 (TTY: 711) Monday through Friday from 8 a.m. to 5 p.m. Apply faster online at [www.phs.org/iplanenroll](http://www.phs.org/iplanenroll).

## RETURN INFORMATION

<b>By Fax:</b>	(505) 923-8252	<b>By Mail:</b>	Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125-7489
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## APPLICATION INSTRUCTIONS

- All applicants must be U.S. citizens, U.S. nationals or have eligible immigration status.
- Make a copy of your completed application for your records.

## STEP 1: TELL US ABOUT YOURSELF

We will need one adult in the family to be the contact person for your application

First Name, MI, Last name & Suffix

Physical Address (required – P.O. Boxes are not allowed)		Apartment or Suite Number	
City	State	ZIP Code	County
Mailing Address (if different from physical address)		Apartment or Suite Number	
City	State	ZIP Code	County
Primary Phone	Secondary Phone	Do you want plan info by email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Number (required)		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)

1. Do **you** need health insurance coverage?  
 Yes  No, I am completing this form to enroll a dependent onto a child-only plan. Go to Step 2
2. If Yes, have you, within the last six months **used \*Tobacco 4 or more times** per week on average?  
(excludes e-cigarettes and religious or ceremonial uses of tobacco)  
 Yes  No

## STEP 2: NOW, TELL US WHO ELSE NEEDS COVERAGE

Name	Relation	Gender	Date of Birth	SSN	*Tobacco Use
First Name, MI, Last Name	Spouse/Child	Male/Female	mm/dd/yyyy	required	see above
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have more dependents to include, make a copy of this page and attach.

**STEP 3: EFFECTIVE DATE SELECTION**

**Open Enrollment** is November 1<sup>ST</sup> through December 15<sup>TH</sup> each year, coverage will begin on January 1<sup>st</sup>.

**Special Enrollment** is available year-round. You must enroll within 60 days of a qualifying life event to be eligible for coverage (i.e. Loss of coverage, relocation with proof of prior coverage, marriage or gaining a dependent). Proof of a qualifying life event is required. The submission deadline is the last day of the month for the 1<sup>st</sup> of the following month.

Please check one:  Next available  Other month \_\_\_\_\_ within 60 days of this application

**STEP 4: TELL US WHAT PLAN YOU WOULD LIKE TO CHOOSE**

Platinum Plan	Gold Plans	Silver Plans	Catastrophic Plan
<input type="checkbox"/> Platinum	<input type="checkbox"/> Gold 1	<input type="checkbox"/> Silver 1 <input type="checkbox"/> Silver 3 <input type="checkbox"/> Silver 4	<input type="checkbox"/> Catastrophic Plan* <i>for individuals under age 30 years.</i>

\*Age 30+ to buy Catastrophic coverage plan with a hardship exemption, you will need to provide Presbyterian Health Plan, Inc. with your Exemption Certificate Number (ECN).

**STEP 5: TELL US IF YOU WOULD LIKE DENTAL AND VISION COVERAGE**

**Dental Coverage** (underwritten and administered by Companion Life Insurance Company)

All plans include the Standard Dental Plan

**Yes, add Premium DENTAL coverage**

**No, do not add premium dental coverage**

If yes, all applicants will be enrolled. The amount listed below will be added to your total monthly premium.

- \$18.15 for a single applicant
- \$35.05 for 2 applicants
- \$59.17 for 3 or more applicants

**Vision Coverage** (underwritten and administered by Vision Service Plan (VSP))

All plans include the Pediatric and Standard Vision Plans

**Yes, add Premium VISION coverage**

**No, do not add premium vision coverage**

If yes, all *adult* applicants (age 19 and older) will be enrolled. The amount listed below will be added to your total monthly premium.

- \$7.13 for each adult applicant

**STEP 6: 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/Debit Card Automatic Bank Draft Bill Me**Credit / Debit Card** MasterCard Visa Discover

Card Account # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name on Card \_\_\_\_\_ Card Expiration Date \_\_\_\_/\_\_\_\_ CSV \_\_\_\_

Card Billing Address (address where you receive 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 7: TERMS AND CONDITIONS**

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 on this application. This authorization is to remain in effect until PHP and/or the financial institution(s) named above are notified in writing. Under the Market Stabilization rule finalized on April 13, 2017, to the extent permitted by State law, Presbyterian Health Plan may attribute to any past-due premium amounts owed to it the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage, for coverage in the 12-month period preceding the effective date. Be aware that failure to pay premiums in a preceding 12-month period may result in your inability to effectuate new coverage until past due premium payments and initial premium payments are satisfied

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](http://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 a.m. to 6 p.m. TTY users please call 711.

If Dental coverage and or Vision coverage is selected, I hereby agree to remain enrolled in the dental plan and or vision plan until my PHP renewal. I authorize the release of any information related to dental and or vision care received and I agree to all the terms and conditions set forth in the dental plan and or vision plan agreements with PHP. Dental coverage is underwritten and administered by Companion Life Insurance Company. Vision coverage is underwritten and administered by Vision Service Plan (VSP).

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.bewellnm.com](http://www.bewellnm.com) if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

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 [www.phs.org/Pages/privacy-security.aspx](http://www.phs.org/Pages/privacy-security.aspx). This authorization shall be valid for two years from this date and you have the right to revoke this authorization at any time 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 I am entitled to a copy of this signed Application upon request. I acknowledge that I have read and understand this Application in its entirety.

Signature of Applicant or Legal Guardian

Today's Date\*

x

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

**AGENTS AND BROKERS INFORMATION**

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

2. Phone Number

3. Organization name

4. Vendor Number