Employer Group Information Application

PRESBYTERIAN
Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Application Instructions

1. Get help with this application by calling us at 505-923-5807 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m. Additional forms may be found online at www.phs.org/employers.
2. Complete this form and fax it to (505) 923-8225 or email it to your account executive.

Step 1 – Employer Group Information

Requested effective date:			
Group name:		Tax identification number:	
Group legal name (if different then above):			
Group contact name:	Group contact title:	Billing contact name and title:	Billing contact title:
Group contact phone:		Billing contact phone:	
Group contact email:		Billing contact email:	
Physical address (P.O. Boxes are not allowed):		Suite number:	
City:	State:	ZIP code:	County:
Billing address (if different from physical address):		Suite number:	
City:	State:	ZIP code:	County:

Is this company affiliated with any other companies? Yes ☐ No ☐ If yes, affiliation's name:

Step 2 – Eligibility and Contribution Guidelines

Waiting Period:

☐ Date of hire
☐ 1st of the month following date of hire
☐ 1st of the month following 30 days of employment
☐ 1st of the month following 60 days of employment
☐ Effective on the 91st date of employment (not eligible for 30-day orientation period)
☐ Group has a 30-day orientation period (waiting period begins after orientation period)

Eligibility:

1. Part-time employment applies to waiting period? Yes ☐ No ☐
2. Group agrees to domestic partner coverage? Yes ☐ No ☐
3. Group is COBRA eligible? Yes ☐ No ☐ If Yes, COBRA Administrator Name
   ____
4. Offering a qualified high deductible plan? Yes ☐ No ☐ If Yes, HealthEquity HSA through Presbyterian? Yes ☐ No ☐ If yes, complete the HealthEquity enrollment forms.
5. Does employer wish to waive the waiting period for initial enrollment? Yes ☐ No ☐
6. Full-time eligible employees scheduled to work _____ hours per week. (30 hours max)

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Premium Contributions

Employee: _____% or $_____ Spouse: _____% or $_____ Dependents: _____% or $_____

Step 3 – Group Census

☐ Group attests they have 50 or less full-time equivalent employees based on IRS guidelines. Use the full-time equivalent employee (FTE) calculator online at https://www.healthcare.gov/shop-calculators-fte to verify your FTE count.

Total employees:	=	
# of part-time or seasonal employees:	-	
# of employees in the waiting period	-	
# of eligible employees (including waivers):	=	
# of employee with other coverage waiving coverage:	-	
# of employee without other coverage waiving coverage:	-	
Total # of employees enrolling:	=	

Total # of employees living and/or working outside of New Mexico:

Step 4 – Medical Plan Selection

You may choose 1- 5 plans between HMO and PPO

☐ **HMO Plans**

Platinum Plan	Gold Plans	Silver Plans	Bronze Plans
☐ Platinum	☐ Gold 1 ☐ Gold 2 ☐ Gold 3 ☐ Gold 4	☐ Silver 1 ☐ Silver 2 ☐ Silver 3 ☐ Silver 4	☐ Bronze 1 ☐ Bronze 2 ☐ Bronze 3

☐ **PPO Plans**

Platinum Plan	Gold Plans	Silver Plans	Bronze Plans
☐ Platinum	☐ Gold 1 ☐ Gold 2 ☐ Gold 3 ☐ Gold 4	☐ Silver 1 ☐ Silver 2 ☐ Silver 3 ☐ Silver 4	☐ Bronze 1 ☐ Bronze 2 ☐ Bronze 3

Step 5 – Dental and Vision Plan Selection

For groups with two or more employees enrolled

DentalSource Dental Plan ☐ Yes ☐ No
If yes, please complete the *separate* **DentalSource Employer Application** and select the High or Standard Option. (*Dental coverage is underwritten and administered by Companion Life Insurance Company)*

Vision Service Plan (VSP) ☐ Yes ☐ No
If yes, please choose plan:
☐ Signature Plan A - $3.20 per member per month
☐ Signature Plan C - $6.10 per member per month
(These riders are available for all small groups to cover adults age 19 and above. Vision coverage is underwritten and administered by Vision Service Plan (VSP)

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Step 6 – Payment Information

Select a payment option (automatic bank draft or bill me)

☐ Checking account ☐ Savings account ☐ Bill me (for groups with 10+ employees enrolled only)

Name of bank:	Name of account holder:
Account number:	Routing number:

Step 7 – Authorizations and Agreements

I hereby authorize and request Presbyterian to initiate and withdraw entries from the account indicated below and the financial institution named below for monthly premium payments required by the Group Subscriber Agreement/Summary Plan Description. This authorization is to remain in effect until Presbyterian and the financial institution named below are notified in writing. I understand that I have the right to terminate this agreement by notifying my financial institution. However, I understand that prearranged withdrawal entries are the required method of premium payment under the Group Subscriber Agreement/Summary Plan Description.

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 acknowledge that I have read and understand this application in its entirety.

Signature of group contact

X____ Date: ______________________

Signature of billing contact

X____ Date: ______________________

Agent and Broker Information

First and last name:	Phone number:
Agency name:	Vendor number: