PRESBYTERIAN
Health Plan, Inc.

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.

RETURN INFORMATION

By Fax:	(505) 923-8252	**By Mail:**	Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125-7489

APPLICATION INSTRUCTIONS

- 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? ☐Yes ☐No Email:	
Social Security Number (required)	Gender: ☐ Male ☐ 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 First Name, MI, Last Name	**Relation** Spouse/Child	**Gender** Male/Female	**Date of Birth** mm/dd/yyyy	**SSN** required	***Tobacco Use** see above
		☐ M ☐ F			☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No

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

PRESBYTERIAN
Health Plan, Inc.

STEP 3: EFFECTIVE DATE SELECTION

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

☐ **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 1st 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

Silver 1
☐

STEP 5: TELL US IF YOU WOULD LIKE DENTAL 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

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_____

PRESBYTERIAN
Health Plan, Inc.

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 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 is selected, I hereby agree to remain enrolled in the dental 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 administered by Davis Vision.

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 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. 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.

PRESBYTERIAN
Health Plan, Inc.

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 Mark, David, Covell	2. Phone Number 505-232-8302
3. Organization name Covell Consultants LLC	4. National Producer Number (NPN) 1218250