

Individual Plan Enrollment Application

If you have questions, you may contact your broker or our Individual Plan Call Center 1-866-8MY-PRES,
Monday through Friday from 8:00 a.m. to 5:00 p.m.

SUBMIT BY FAX:
(505) 923-5888

SUBMIT BY MAIL:
Presbyterian Insurance Company, Inc.
P. O. Box 26267
Albuquerque, NM 87125-6267

APPLICATION INSTRUCTIONS

1. This Application must be completed with black or blue ink only. Illegible Applications or Applications completed in pencil or erasable ink will be returned. Changes or corrections to this Application must be made by striking out the change/mistake with a line and initialing the change. Do not use correction tape or fluid.
2. Questions must be answered with complete details given for any "yes" answers. You are responsible for the accuracy and completeness of all information entered on this form. Full disclosure is essential in processing your application; incomplete applications may result in delays and/or declination. If more space is needed, attach a separate page(s) and list section(s) and question numbers, then sign and date each page.
3. All legal-age Applicants or the parent/legal guardian of a minor child Applicant must personally sign and date this Application. If your spouse or any dependent(s) age 18 or over are also applying for coverage, they must personally sign and date this Application on the appropriate signature line.

SECTION 1: APPLICANT INFORMATION

Primary Applicant

*Tobacco use in last 24 months

First Name, MI, Last Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mo/day/yr)	Social Security Number	Height (ft., in.)	Weight (lbs.)	Tobacco use* Y <input type="checkbox"/> N <input type="checkbox"/>
Residential Address (No P.O. Boxes)		City	State	County	ZIP Code	
Home Phone	Work / Message Phone	Spouse's Work / Message Phone (if applying)		E-mail Address		
Mailing Address		City	State	County	ZIP Code	

Other Applicants

Legal Spouse / Dependent Children (dependent children must be under age 25 and unmarried).

*Tobacco use in last 24 months

Name First Name, MI, Last Name	Relation (Spouse /child)	Gender	DOB (m/d/yr)	SSN	Height (ft., in.)	Weight (lbs.)	Tobacco use*
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>

If any one Applicant is denied coverage, do you wish to cover the remaining Applicants? Y N

SECTION 4: GENERAL INFORMATION

1. Where did you hear about Presbyterian's Individual Plans?
 Broker Newspaper TV Radio Direct Mail My Doctor
 Other _____
2. Are all Applicants New Mexico residents or live in New Mexico at least six (6) months each year? Yes No
3. Has any Applicant applying for coverage had claims in excess of \$5,000 during the past twelve (12) months?
 If "yes," Applicant name _____ Yes No
 condition/treatment) _____
4. Has any person applying for coverage been denied health insurance coverage in the past (6) six months?
 If "yes," Applicant name _____ Insurance company _____ Yes No
 Reason for decline _____

SECTION 5: AUTOMATIC DECLINATION OF COVERAGE

- A.** Applicants in the following categories are **likely to be declined coverage** for Presbyterian's Individual Plans.
- Pregnant or an expectant father.
 - Currently anticipating a surgical procedure of any kind.
 - Infants less than 31 days old.
 - Parents of infant less than 31 days old.
- B.** Applicants who have been diagnosed or treated for the following medical conditions are also likely to be declined coverage. Please review these conditions below.
- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Lupus (SLE), Systemic | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Diabetes (Insulin Dependent) | <input type="checkbox"/> Metastatic Cancer | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> ALS-(Lou Gehrig's Disease) | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Transplant (except for corneal) |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis C (Active) | <input type="checkbox"/> Muscular Atrophy or Dystrophy | |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Myasthenia Gravis | |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Intermittent Claudication | <input type="checkbox"/> Open Heart Surgery | |
| <input type="checkbox"/> Coronary Insufficiency | <input type="checkbox"/> Juvenile Diabetes | <input type="checkbox"/> Paraplegia or Quadriplegia | |
| <input type="checkbox"/> Coronary Occlusion | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Polycystic Kidneys | |

SECTION 6 MEDICAL QUESTIONNAIRE

- All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.
- If you answer "yes" to ANY question in Section 6, please give complete details in Section 7. Please include the date started and the recovery date for any condition, injury, symptom, or diagnosis listed.
- Within the last **10 years**, has any person applying for coverage been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended for treatment for the following? (Please mark "Yes" or "No"):

If any boxes are marked "yes" (☒ Yes), also circle the condition, e.g., migraines, and give complete details in Section 7.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Migraines, headaches, epilepsy or seizure disorder, head injury or concussion, any neurological disorder, neuropathy, paralysis, multiple sclerosis, or any other central or peripheral nervous system disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Attention deficit disorder, anxiety, depression or chemical imbalance, insomnia, bipolar disorder, mental retardation, any behavioral, emotional or mental disorder, eating disorder, pervasive development disorder or autism spectrum disorder, marital or any form of counseling or therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Chest pain, palpitations, heart murmur, mitral valve prolapse, arrhythmia or irregular heartbeat, heart attack, stroke or TIA, or any other heart or circulatory disorder or condition, or hypertension / high blood pressure (HBP)?
If "yes" to HBP, provide 3 readings and their dates within the last year.
_____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<p>4. Elevated cholesterol, triglycerides or other lipids (including if controlled by diet or exercise)? If "yes," provide the date and results of most recent testing: Date: _____ Total Chol: _____ HDL: _____ Triglycerides: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>5. Varicose veins, spider veins, varicosities, blood clot, anemia, or any other blood disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>6. Asthma, allergies, sinusitis, bronchitis, pneumonia, tuberculosis, apnea, chronic obstructive pulmonary disease (COPD), emphysema, breathing difficulty, or any other lung or respiratory disease, disorder or condition?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>7. Acid reflux, gastroesophageal reflux (GERD), Barrett's or any other disorder of the esophagus, irritable bowel syndrome (IBS), colitis, diverticular disease, chronic diarrhea or intestinal problem, ulcer, hernia, hemorrhoids or rectal disorder, or any other digestive disorder or condition? If "yes" to hernia, indicate type: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>8. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests, cirrhosis, or hepatitis? If "yes" to hepatitis, indicate which type: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>9. Cancer, tumor, growth, cyst, polyp, enlarged lymph node(s), or leukemia? If "yes," indicate diagnosis & location _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>10. Acne, keratosis, psoriasis, basal cell carcinoma, and malignant melanoma, lesions of the skin or mouth, hemangioma, or any other skin disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>11. Kidney stones, urinary reflux, urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>12. Breast cyst or nodule, gynecomastia, fibrocystic breast disease, breast implants, or any other disease or disorder of the breast?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>13. Back or spinal disorder, herniated, bulged, protruded, ruptured or slipped disc, degenerative disc disorder, or any other injury to disease or disorder of the back or spine?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>14. Arthritis (e.g. osteoarthritis, rheumatoid, psoriatic, etc), gout, bursitis, carpal tunnel syndrome, pinched nerve, bunion, temporomandibular joint syndrome (TMJ), or any injury to, disease or disorder of the knees, shoulders, jaw bones, muscles or joints, joint replacement, or received chiropractic adjustments or manipulation therapy?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>15. Hypothyroidism, hyperthyroidism, Graves' disease, goiter, nodule or any other thyroid disorder, diabetes, elevated blood sugar, glucose intolerance, insulin resistance or any other metabolic, endocrine, pituitary or adrenal disorder, lupus, chronic fatigue syndrome, connective tissue or autoimmune disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>16. Cataracts, glaucoma, hearing loss, deviated nasal septum, or any other eye, ear, nose, speech or throat disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>17. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV positive or other immune disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>18. For all Male applicants (adults and children) Prostate disorder, elevated prostate specific antigen (PSA), sexually transmitted disease, genital warts, herpes, erectile dysfunction, or any other disease or disorder of the genital or reproductive system?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>19. For all Female applicants (adults and children) Fibroid or uterine tumor, ovarian cyst, endometriosis, infertility, cystocele, rectocele, sexually transmitted disease, cervical dysplasia, genital warts, herpes, HPV, or any other disease or disorder of the genital or reproductive system? If "yes" to cervical dysplasia, circle type: Atypical Squamous, Squamous, low grade; Squamous, high grade; Glandular, and indicate length of time since normal Pap test _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>20. During the last 12 months, has any applicant been prescribed or advised to take medication (other than for the common cold or flu or contraceptives to prevent pregnancy) other than indicated elsewhere on this application? If unsure of the reason for any ongoing medication use, please verify with your physician.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>21. A. Question for all FEMALE applicants (including dependents): Is any female applicant currently pregnant or now an expectant parent? If “yes,” coverage cannot be offered</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>B. Question for all MALE applicants (including dependents): Is any male applicant now an expectant parent? If “yes,” coverage cannot be offered</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>22. Does any applicant have or ever had an implant (e.g., breast, chin, or penile implant, etc.), internal fixation (e.g., pins, plates, rods, screws or spinal cage), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device other than indicated elsewhere on this application? If “yes” to breast implants: Indicate reason(s) for breast implants: If “yes” to breast implants: Have there been any complications or has either of the breast implants(s) been replaced?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>23. Does any applicant drink beer or alcohol? If “yes,” please complete the following: Note: 1 drink is equivalent to one 12-oz beer, one 5-oz glass of wine or 1.5- oz of hard liquor Applicant’s name: _____ Average number of drinks per week: _____ Applicant’s name: _____ Average number of drinks per week: _____ Applicant’s name: _____ Average number of drinks per week: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>24. Has any applicant ever been advised to seek treatment for alcohol use or been advised to reduce alcohol intake?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>25. Has the applicant been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>26. Has any applicant been counseled for, diagnosed, or treated for drug or chemical use or dependency? If “yes,” indicate name of drug or chemical: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>27. Has any applicant discussed or been advised to have treatment, testing, counseling, therapy, or surgery which has not yet been performed?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>28. Has any applicant ever been seen tested, hospitalized, or had surgery for a bypass, angioplasty, stent, aneurysm, valve replacement, cancer, stroke, gastric or weight loss surgery, congenital abnormality, or organ transplant other than indicated elsewhere on this application?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered “YES” to any questions in Section 6, please give complete details in Section 7

SECTION 8: BILLING INFORMATION

Authorization Agreement for Prepayments

(Presbyterian Insurance Company, Inc. – Individual Plans)

Your coverage will become effective on either the first (1) or the fifteenth (15) day of the month following approval, according to what you chose in the *Effective Date Selection* in Section 2 of this Application.

Presbyterian Insurance Company, Inc (PIC) is pre-paid health coverage, which means you pay your premium payment for coverage prior to the month of coverage. Please select your premium payment option below by putting a checkmark in the appropriate boxes, and then complete the corresponding financial information. Your coverage will become effective either on the first (1) or the fifteenth (15) of the month following approval, per your specified Effective Date Selection. If you are accepted, you will receive an Acceptance letter with notification of the effective date of coverage, each individual approved for coverage, and the amount that has been charged to your account. You may change the method of your premium payments by contacting the Presbyterian Customer Service Center by e-mail at info@phs.org. You may also call (505) 923-6980 or toll-free at 1-800-923-6980, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407. The effective date of the change will be dependent on the time of month the request is made, and the type of payment method requested.

Please do not send your estimated premium payment with your Application. Any premium payments sent before acceptance by PIC will not constitute approval or acceptance of health insurance coverage or bind coverage by PIC, including but not limited to any deposit, negotiation, or holding of such premiums or payments by PIC. I understand and agree that not withstanding anything in the Application to the contrary; no coverage shall be considered accepted until approved by PIC.

Premium Payment Option: Please select one of the following options to make your premium prepayments

- Credit Card Debit Card Automatic Bank Draft

Credit Card/Debit Card*

- MasterCard VISA

*Credit or Debit cards must have either a MasterCard or VISA Logo to be accepted for payment.

Card Account # _____ - _____ - _____ - _____

Name on Card _____ Card Expiration Date ____/____

Card Billing Address (address where you receive your Credit/Debit card statements).

Street Address _____

City _____ State _____ ZIP _____

Automatic Bank Draft

- Checking Account Savings Account

Name of Financial Institution: _____

Account Number: _____ Routing Number _____

Name on Financial Institution Account: _____

SECTION 9: TERMS AND CONDITIONS

Applicants accepted 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.

Please be aware of a few major medical services that are not covered on this plan. The exclusions listed below are a summary of exclusions, and cannot modify or affect the *Subscriber Agreement* in any way, nor shall you accrue any rights because of any statement or omission from this summary. Covered benefits and services are subject to the provisions of the *Subscriber Agreement*. For a more complete list of exclusions, please refer to the *Schedule of Benefits*. The *Schedule of Benefits* may be found at www.phs.org/healthplans or you may contact our Individual Plan Call Center at 1-866-8MY-PRES (1-866-869-7737), Monday through Friday from 8:00 a.m. to 5:00 p.m.

- Benefits including, but not limited to, any condition that is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care, except as provided when a Maternity Rider is available for purchase.
- Mental Health drugs and services or alcohol and substance abuse services (except for detoxification only).
- Artificial conception/infertility services including, but not limited to; diagnosis, treatment drugs and injections, artificial insemination, donor sperm, In-vitro, GIFT and ZIFT fertilization.
- A Pre-existing Condition Limitation will apply to any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the (6) six-month period prior to the Member's enrollment under this plan unless prior proof of Creditable Coverage is provided.

Proof of coverage must be provided for pre-existing condition credit. A Certificate of Creditable Coverage from prior carrier/insurance company is an acceptable form of proof. Failure to provide proof of prior coverage may subject you or your family members to the full Pre-existing Condition Limitation with no credit for prior coverage. You are entitled to a Certificate of Creditable Coverage from your prior carrier/insurance company. Pre-existing Conditions are diseases or conditions for which medical advice, diagnosis, care or treatment was recommended or received within the (6) six-month period before the individual's effective date on this plan.

SECTION 10: REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I hereby consent, to the extent permitted by applicable law, to the use by or the release of my Protected Health Information (PHI) by any person or entity including without limitation, practitioners, providers, and insurance companies to Presbyterian Insurance Company or its designees for any permitted purpose, including but not limited to; quality assurance, utilization review, processing of claims, financial audits, or other purposes related to the treatment, payment or healthcare operations activities of Presbyterian Insurance Company, Inc.

I understand that I am applying for individual health insurance coverage offered by Presbyterian Insurance Company, Inc.

I understand that Presbyterian Insurance Company, Inc. does not intend this health insurance coverage to be that of a Small Employer Group health plan, and it is not represented as such. The state of New Mexico has enacted legislation governing Small Group health plans. This legislation impacts how insurers provide coverage to employees of small companies whose employees number from 2 to 50.

I understand that because this coverage is not that of a group health plan, I will not be entitled to any rights or protections governing such plans, including, for example, guaranteed renewability and portability.

I understand and acknowledge I am fully responsible for the payment of all premiums associated with this individual coverage and my employer is not paying, in full or in part, for any of the premiums or costs associated with any such coverage. My employer may only provide administrative support for the billing and/or submission of my individual Presbyterian Insurance Company, Inc. premium, which is paid in full by me.

Further, I understand that in order for my employer to remit premium payments on my behalf, I authorize my employer access to (1) information regarding my (and any eligible dependent's) enrollment (as well as any changes thereto), and (2) information regarding the amount of my premium payment.

I understand that I am entitled to a copy of this Application if I request it.

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

SECTION 10: REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS (cont.)

Authorization

By **initialing below**, I hereby authorize Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) or and/or my broker on my behalf to accept coverage to enroll all Applicants with an “approved” and/or “conditional approval” status. *Approved* means accepted to enroll in the plan originally requested. *Conditional approval* means the Underwriters have offered a different plan to the Applicant, rather than declining coverage. _____ **Initial**

Upon acceptance and enrollment in a Presbyterian Individual Care Plan, I hereby authorize and request Presbyterian Insurance Company, Inc. 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 approved and enrolled individuals listed in Section I of this Application only.

This authorization is to remain in effect until Presbyterian Insurance Company, Inc. and the financial institution(s) named above are notified in writing or through Presbyterian’s designated website.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or 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 Insurance Company, Inc. may terminate a member for any type of fraudulent activity.

I **agree** by completing this Application I understand and agree that I have read this Application thoroughly and have verified the accuracy of all information contained herein, whether entered by me or by Presbyterian on my behalf, and warrant and represent my current and continuing authority to act on behalf of myself and all Dependents with respect to every provision of the *Subscriber Agreement*. All information on this form is correct and true. I understand this information is the basis on which coverage is issued under the plan. I understand that if approved, I will receive my Presbyterian Insurance Company, Inc. Subscriber Agreement, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

_____	X	_____
Name of Applicant (please print) (or Legal Guardian if Applicant is a minor)	Signature of Applicant (required) (or Legal Guardian if Applicant is a Minor)	Today’s Date
_____	X	_____
Name of Applicant’s spouse <i>If applying (please print)</i>	Signature of Applicant’s Spouse <i>If applying (required)</i>	Today’s Date
_____	X	_____
Name of Applicant’s Dependent <i>If applying and over 18 (please print)</i>	Signature of Applicant’s Dependent <i>If applying and over 18 (required)</i>	Today’s Date
_____	X	_____
Name of Applicant’s Dependent <i>If applying and over 18 (please print)</i>	Signature of Applicant’s Dependent <i>If applying and over 18 (required)</i>	Today’s Date

BROKER/PRODUCER

For Agent/Broker Use Only – must be completed for commissions to be paid.

Broker Name: _____ Agency Name: _____

Agent / Broker Phone Number: _____ Agent / Broker Presbyterian ID Number: _____