

Individual Plan Member Add or Move Dependent Form

This form is for Individual Plan members requesting to add or move a dependent to or from your current individual policy.

Please complete the front and back of this form to avoid delay or possible denial of request. If you have questions, you may contact your broker, or our Individual Plan Call Center at 1-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Please FAX this form to: (505) 923-5888				Please MAIL this form to: Presbyterian Insurance Company, Inc. P.O. Box 26267 Albuquerque, NM 87125-6267					
MEMBER INFORMATION									
Primary Policy Holder's Name:		Social Security Number:		Member ID Number:		Date of Birth:	Phone Number:		
Address:		City/County/State:		ZIP:		E-mail:			
CHECK (✓) YOUR CURRENT PLAN									
<input type="checkbox"/> PresMetro Plan		<input type="checkbox"/> PresSolo Plan		<input type="checkbox"/> Individual Care Plan		<input type="checkbox"/> Advantage Care Plan			
<input type="checkbox"/> Select Plan		<input type="checkbox"/> Classic Plan		<input type="checkbox"/> Savvy100 Plan					
Deductible Level _____			Prescription Level _____						
ADD OR MOVE A DEPENDENT									
Check the correct box below to show the reason for the ADD or MOVE. You must complete and attach a Medical Questionnaire when adding a spouse or dependent. The Medical Questionnaire is <i>not</i> required when adding a newborn, newly-adopted child or a child for whom a Subscriber becomes a legal guardian within 31 days of birth, date of placement, or the court order granting guardianship.									
<input type="checkbox"/> Newborn Add*/Date of Birth: _____			<input type="checkbox"/> Spouse/Dependent Add						
<input type="checkbox"/> Adoption* Date of Placement: _____			<input type="checkbox"/> Dependent move to a separate policy (same benefit plan)						
<input type="checkbox"/> Court Order*/Date of Order: _____			<input type="checkbox"/> Other, please describe: _____						
USE THIS SECTION TO ADD OR MOVE A DEPENDENT									
Only your spouse and eligible unmarried dependent children under age 26 may be included in this section.									
Social Security Number	Last Name	First Name	MI	DOB	Gender	Age	Relationship	AM =Add ME =Move	Effective Date

** Please refer to your Subscriber Agreement for information regarding qualifying events and required documentation.*

Presbyterian determines actual effective dates. Your requested effective date is not guaranteed. If your request is received by the last day of the month your effective date will be the first of the following month. Exceptions: Newborns, newly-adopted child or a child for whom a Subscriber becomes a legal guardian, the effective date will be the date of birth, date of placement, or the court order granting guardianship.

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS DOCUMENT

You may download and print the Presbyterian Medical Questionnaire from our website at www.phs.org/healthplans. You may also request the Medical Questionnaire to be sent to you by calling us toll-free 1-866-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m. **Coverage requests are subject to medical underwriting and are not guaranteed.**

I agree: By signing this Application I warrant that I have read this Application and warrant my current and continuing authority to, and on behalf of, myself and all Dependents for whom I have legal authority to act on behalf of with respect to every provision of the Subscriber Agreement. All information on this Form is correct and true. I understand that is the basis on which coverage is issued under the Plan. I understand I will receive my applicable Presbyterian Health Plan (PHP) or Presbyterian Insurance Company Inc. (PIC) *Subscriber Agreement*, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

I hereby consent 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/PIC or its designees for any permitted purpose. Purposes 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 PHP/PIC. This consent shall not permit use or disclosure of PHI when authorization is required by law.

I hereby authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Presbyterian Insurance Company, Inc. for the purpose of evaluating my application for insurance. 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. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Presbyterian Insurance Company, Inc.

I hereby authorize Presbyterian Health Plan or Presbyterian Insurance Company, Inc. (Presbyterian) and/or a broker on my behalf to accept coverage to enroll all applicants with an "approved" status. Approved means accepted to enroll in the plan originally requested.

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 INSURANCE COMPANY, INC. MAY TERMINATE A MEMBER FOR ANY TYPE OF FRAUDULENT ACTIVITY.

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

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

<hr/> Name of Applicant <i>(Please print)</i> (Or Legal Guardian if Applicant is a Minor)	<hr/> X Signature of Applicant <i>(Required)</i> (Or Legal Guardian if Applicant is a Minor)	<hr/> Today's Date
<hr/> Name of Applicant's Spouse <i>If applying (Please print)</i>	<hr/> X Signature of Applicant's Spouse <i>If applying (Required)</i>	<hr/> Today's Date
<hr/> Name of Applicant's Dependent <i>If applying and over 18 (Please print)</i>	<hr/> X Signature of Applicant's Dependent <i>If applying and over 18 (Required)</i>	<hr/> Today's Date
<hr/> Name of Applicant's Dependent <i>If applying and over 18 (Please print)</i>	<hr/> X Signature of Applicant's Dependent <i>If applying and over 18 (Required)</i>	<hr/> Today's Date