PRESBYTERIAN

Presbyterian Insurance Company, Inc.

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 their 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:	

INSTRUCTIONS TO ADD OR MOVE A DEPENDENT

- You **must** complete and attach a **Dependent Add Medical Questionnaire** when **adding** a spouse or dependent. The Medical Questionnaire is *not* 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
- You **must** include **Qualifying Event*** documentation with this form if you are requesting to add your dependent to your existing policy. If **Qualifying Event*** documentation is not included, your dependent may apply for a new policy using an Individual Plan Enrollment Application.

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

☑ CHECK THE CORRECT BOX BELOW TO SHOW THE REASON FOR THE ADD OR MOVE

☐ Newborn Add - Date of Birth: _____
☐ Adoption - Date of Placement: _____
☐ Court Order - Date of Order: _____
☐ Marriage - Date of Marriage: _____
☐ Spouse or Dependent Add
☐ Dependent move to a separate policy - same benefit plan

LIST THE DEPENDENT(S) INFORMATION BELOW

Only your spouse and eligible 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

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 Add Dependent Medical Questionnaire from our website at www.phs.org/healthplans. You may also request the Add Dependent Medical Questionnaire to be sent to you by calling us toll-free 1-866-869-7737, 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.

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

PRESBYTERIAN INSURANCE COMPANY INC.

Individual Plan Add Dependent Medical Questionnaire

This questionnaire is for Individual Plan members requesting to add a dependent to their policy.

Please complete 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**

APPLICATION INSTRUCTIONS

1. This form must be completed in addition to the Individual Plan Member Add Dependent Form.
2. This Questionnaire must be completed with **black or blue ink** only. Please print legibly. Changes or corrections to this Questionnaire must be made by striking out the change/mistake with a line and initialing the change. Do not use correction tape or fluid.
3. 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 request; incomplete Questionnaires 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.
4. All legal-age Applicants or the parent/legal guardian of a minor child Applicant must personally sign and date this Questionnaire. If your spouse or any dependent(s) age 18 or over are also applying for coverage, they must personally sign and date this Questionnaire on the appropriate signature line.

SECTION 1: APPLICANT INFORMATION

Primary Policy Holder's Name:	Social Security Number:	Member ID Number:	Date of Birth:	Phone Number:

Use the following to list the member(s) requesting a change to their coverage or list your legal dependent(s) that you are requesting to add to your coverage.

Name First Name, MI, Last Name	**Relation** Self, Spouse, Child	**Gender**	**DOB** (m/d/yr)	**Height** (ft., in.)	**Weight** (lbs.)	**Tobacco use**
		M ☐ F ☐				Y ☐ N ☐
		M ☐ F ☐				Y ☐ N ☐
		M ☐ F ☐				Y ☐ N ☐
		M ☐ F ☐				Y ☐ N ☐
		M ☐ F ☐				Y ☐ N ☐

If any one Applicant is denied coverage, do you wish to cover the remaining Applicants? ☐ Yes ☐ No

SECTION 2: ELIGIBILITY & GENERAL INFORMATION

1. Do all Applicants live in New Mexico at least six (6) months each year?	☐ Yes ☐ No
2. Has any Applicant previously applied for coverage with Presbyterian in the last six (6) months? If "yes," Applicant name _____	☐ 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_____ Condition/treatment_____	☐ Yes ☐ No
4. Has any person applying for coverage been denied health insurance coverage in the past (6) six months? If "yes," Applicant name _____ Insurance Company _____ Reason for decline_____	☐ Yes ☐ No

SECTION 3: MEDICAL QUESTIONNAIRE

- All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.
- Within the last **10 years**, please mark "Yes" or "No" ☑ if any person applying for coverage has been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended treatment for the following.

If you answer "Yes" to ANY question below, underline or circle the condition, if applicable, and provide details in Section 4.

1. Any migraines, headaches, epilepsy, seizures, head injury, concussion, paralysis, neurological disorder, multiple sclerosis, ADD/ADHD, anxiety, depression, schizophrenia, obsessive compulsive disorder (OCD), bipolar disorder, mental retardation, autism, or any other nervous system or behavioral, mental or psychological disorder or condition?	☐ Yes	☐ No
2. Any 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. _____ _____ _____	☐ Yes	☐ No
3. 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: _____	☐ Yes	☐ No
4. Any blood disorders, hemophilia, blood clot, anemia, varicose or spider veins, varicosities, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV positive or any other immune system or blood disorder?	☐ Yes	☐ No
5. Any 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?	☐ Yes	☐ No
6. Any colitis, ulcerative colitis, irritable bowel syndrome (IBS), Crohn's disease, liver, stomach or pancreas disorders, hepatitis, ulcer, hernia, GERD, diverticulitis, esophagitis, Barrett's esophagus, chronic diarrhea, rectal, colon or other digestive disorder or condition? If "yes" to hernia, indicate type: _____ If "yes" to hepatitis, indicate which type: _____	☐ Yes	☐ No
7. Any cancer, tumor, growth, cyst, polyp, enlarged lymph node(s), or leukemia? If "yes," indicate diagnosis & location _____	☐ Yes	☐ No

If you answered "YES" to any questions on this page, please give complete details in Section 4.

SECTION 3: MEDICAL QUESTIONNAIRE (CONT)

8. Any acne, keratosis, psoriasis, basal cell carcinoma, and malignant melanoma, lesions of the skin or mouth, hemangioma, or any other skin disorder?	☐ Yes	☐ No
9. Any kidney stones, urinary reflux, urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney?	☐ Yes	☐ No
10. Any breast cyst or nodule, gynecomastia, fibrocystic breast disease, breast implants, or any other disease or disorder of the breast?	☐ Yes	☐ No
11. Any back, spine, neck or disc disorder, pinched nerve, whiplash, back pain, strain or curvature? Any arthritis, gout, bunion, bursitis, carpal tunnel syndrome, fracture, TMJ, or disorder or pain in any joints, knee, shoulder, jaw or joint replacement, or chiropractic adjustments, physical therapy or manipulations? If "yes" to **arthritis**, indicate type:_____ Location: _____	☐ Yes	☐ No
12. Any 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?	☐ Yes	☐ No
13. Any cataracts, glaucoma, hearing loss, deviated nasal septum, or any other eye, ear, nose, speech or throat disorder?	☐ Yes	☐ No
14. 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?	☐ Yes	☐ No
15. 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** indicate type and length of time since normal Pap test: Type: _____ Length of time: _____	☐ Yes	☐ No
16. 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.	☐ Yes	☐ No
17. Applies to both **MALE** and **FEMALE** applicants (including dependents): Is <u>any</u> applicant currently **pregnant** or now an **expectant parent**? If "yes," coverage cannot be offered. Exception: Applicants under age 19 applying for Classic for Kids, (child-only guaranteed issue plan for children under age 19).	☐ Yes	☐ No
18. 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:** Have there been any complications or has either of the breast implants(s) been replaced? ☐ Yes ☐ No ☐ Cosmetic Reasons ☐ Disease/Illness/Injury/Congenital Anomaly	☐ Yes	☐ No
19. 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:_____	☐ Yes	☐ No
20. Has any Applicant been diagnosed with, advised to seek treatment for, been counseled, or treated for alcohol, chemical or drug use, abuse or dependency? If "yes", name of drug or chemical:_____(and provide details/dates in section 7)	☐ Yes	☐ No

If you answered "YES" to any questions on this page, please give complete details in Section 4.

SECTION 3: MEDICAL QUESTIONNAIRE (CONT)

21. Has any applicant been advised to have or discussed any treatments, diagnostic testing, counseling, therapy, hospitalization, surgery or medications that have not yet been performed?	☐ Yes	☐ No
22. 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?	☐ Yes	☐ No

23. Complete the following for **all** Applicants applying for coverage:

Applicant's Name	Date of last routine physical	Exam Results *Abnormal results include any recommendations for additional testing, medication or follow-up. **If abnormal, give details in Section 4.**	
		☐ Normal	☐ Abnormal *
		☐ Normal	☐ Abnormal *
		☐ Normal	☐ Abnormal *
		☐ Normal	☐ Abnormal *
		☐ Normal	☐ Abnormal *

If you answered "YES" to any questions on this page, please give complete details in Section 4.

SECTION 4: DETAILS OF HEALTH HISTORY

If you answered "yes" to ANY question in Section 3 – Health History/Medical Questions, please provide further information in the spaces below. Be sure to use the example entry as your guide. **If more space is needed, attach a separate page, which must be signed and dated.**

Q #	Applicant affected	Condition, Injury, Symptom, or Diagnosis: Description (specify left or right if applicable)	Date started	Date of recovery (If applicable)	Types of treatment including surgery or procedure(s)	Medications prescribed. Are you currently taking? Indicate Yes or No	Treating Physician's name
3 Example Entry	Joe Smith	High Blood Pressure	6/95	No, Ongoing	Stress Test	40 MG Atenolol, once daily. Yes, still taking	Dr. Smith

In order to process your application, the Underwriting Department may need to contact you to request additional information. Please ensure that you have completed the daytime phone number in Section 1.

SECTION 5: REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

Authorization

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" status. *Approved* means accepted to enroll in the plan originally requested**.**

Upon acceptance and enrollment in a Presbyterian Individual Care Plan, **I hereby authorize** and request Presbyterian Insurance Company, Inc. to initiate withdrawal entries 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. is notified in writing of the request to terminate the policy.

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.

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 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. If the applicants refuse to sign the application, we will be unable to process the application for review for enrollment in Presbyterian Insurance Company, Inc.

	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 If applying *(please print)*	**Signature of Applicant's Spouse** If applying *(required)*	**Today's Date**
	X	
Name of Applicant's Dependent If applying and over 18 *(please print)*	**Signature of Applicant's Dependent** If applying and over 18 *(required)*	**Today's Date**
	X	
Name of Applicant's Dependent If applying and over 18 *(please print)*	**Signature of Applicant's Dependent** If applying and over 18 *(required)*	**Today's Date**