

**Individual Plan Member Benefit Change Form**

**This form is for Individual Plan members requesting a change to their current individual 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 <b>FAX</b> this form to: <b>(505) 923-5888</b>	Please <b>MAIL</b> this form to: <b>Presbyterian Insurance Company, Inc.</b> P.O. Box 26267 Albuquerque, NM 87125-6267
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**MEMBER INFORMATION**

Primary Policy Holder's Name	Social Security No.:	Member ID No.:	Date of Birth	Phone No.:
Address:	City/County/State:	ZIP:	E-mail:	

**SELECT YOUR CURRENT PLAN (✓)**

PresMetro     
  PresSolo     
  Individual Care     
  Advantage Care

Deductible Level \_\_\_\_\_ Prescription Level \_\_\_\_\_

- **Plan change requests within your product** (i.e., PresMetro to PresMetro): \*One change is allowed during each 12-month period in addition to your plans yearly renewal event. You must complete and attach a Medical Questionnaire form for all individuals applying.
- **Plan change requests outside of your product** (i.e., PresMetro to PresSolo): \*Plan change requests outside of your product are permitted at any time. You must complete and attach a Medical Questionnaire form for all individuals applying.
- If approved, and your request was received by the 10th of the month, your effective date will be the first of the following month. Presbyterian determines effective dates for all Member Benefit Change Requests. \*Subject to Medical Underwriting approval

**CHECK (✓) THE BOXES BELOW FOR YOUR BENEFIT CHANGE REQUEST**

Note: If you do not choose a Prescription Selection, the plan will default to the Standard Rx benefit or Option # 1

Plan:                       PresMetro Plan \*       PresSolo Plan \*  
 Deductible Selection:     \$500       \$750       \$1,000       \$2,000       \$5,000  
 Prescription Selection:    \$10/35/75 Standard Rx     0/\$10 Generic Only Rx     No Rx  
 Additional Dental Selection (premium is per member per month)  
 PresMetro/PresSolo Enhanced Dental \$19.50

PresMetro and PresSolo Plans include Standard dental and vision benefits

*\*Service Area Restrictions Apply*

**Individual Care Plan**

Deductible Selection:     \$500     \$750     \$1,000     \$1,500     \$2,000     \$2,500

Prescription Selection is included and is Standard Rx \$10/35/55

**Advantage Care Plan** (Health Savings Account qualified High Deductible Health Plan)

Deductible Selection:     \$1,200 Ind / \$2,400 Family     \$2,500 Ind / \$5,000 Family     \$5,000 Ind / \$10,000 Family

Prescription Selection:    20/20/30% Option #1       No Rx Option #2

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS DOCUMENT

If currently enrolled in a Maternity Rider, would you like to continue your coverage?

Yes  No

If currently enrolled in Delta Dental's Enhanced Dental option, would you like to continue coverage?

Yes  No

You may download and print the Presbyterian Medical Questionnaire from our website at [www.phs.org/healthplans](http://www.phs.org/healthplans). You may also request the Medical Questionnaire to be sent to you by contacting us at the toll-free number listed on this form. Plan selection change requests are subject to medical underwriting and are not guaranteed. Covered benefits and services are subject to the provisions of the Subscriber Agreement. For a complete list of exclusions, please refer to the *Schedule of Benefits*. The *Schedule of Benefits* may be found at [www.phs.org/healthplans](http://www.phs.org/healthplans), or you may contact our Individual Plan Call Center at 1-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m.

**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.

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