

### Individual Plan Benefit Change Medical Questionnaire

**This questionnaire 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> <b>P.O. Box 26267</b> <b>Albuquerque, NM 87125-6267</b>
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#### INSTRUCTIONS

1. This form must be completed in addition to the Individual Plan Member Benefit Change 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

Primary Policy Holder's Name:	Social Security Number:	Member ID Number:	Date of Birth:	Phone Number:
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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 <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?  Yes  No

#### SECTION 2

1. Are all Applicants New Mexico residents or live in New Mexico at least six (6) months each year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Has any Applicant applying for coverage had claims in excess of \$5,000 during the past twelve (12) months? If "yes," please provide detail (condition/treatment) _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Has any person applying for coverage been denied health insurance coverage in the past six (6) months? If "yes," Applicant name _____ Insurance company _____ Reason for decline _____	Yes <input type="checkbox"/> No <input type="checkbox"/>

### SECTION 3: 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 3, please give complete details in Section 4. 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 4.

1. Have you or a dependent undergone surgery, an outpatient procedure, or required hospitalization in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or a dependent been treated for AIDS/HIV, Cancer, Chronic Airway Obstruction, Diabetes, Heart Disease, Hepatitis, Liver Disease, Lupus, Renal Failure, Rheumatoid Arthritis or other Autoimmune or Connective Tissue Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or a dependent been treated for ALS/ Lou Gehrig's Disease, Cerebral Palsy, Cystic Fibrosis, Head Injury, Hemophilia or other Blood Disorder, Multiple Sclerosis, Myasthenia Gravis, Paralysis, Parkinson's Disease or Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you, or a dependent currently pregnant, or an expectant father?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you or a dependent have a condition which may lead to treatment, surgery or hospitalization in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you or a dependent taken any prescribed medication(s), other than birth control to prevent pregnancy, during the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to any questions in Section 3, please give complete details in Section 4.

### SECTION 4: DETAILS OF HEALTH HISTORY

If you answered "yes" to ANY question in Section 3 – Medical Questionnaire, 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.

Question number	Person affected	Condition, Injury, Symptom, or Diagnosis			Was recovery complete?	Types of treatment including surgery or procedure(s)	Medications prescribed. Are you currently taking? Indicate Yes or No
		Description (specify left or right if applicable)	Date started	Date of recovery (If applicable)			
3 <b>Example Entry</b>	Joe Smith	High Blood Pressure	6/95		No, Ongoing	Stress Test	40 MG Atenolol, once daily. Yes, still taking.

## 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.

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 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 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 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.

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