

Individual and Family Plan Enrollment Form

Get help with this form by contacting us at 1-866-869-7737 (TTY: 711) Monday through Friday from 8 a.m. to 5 p.m. or apply faster online at www.phs.org/iplan.

Important: This is an Off Exchange enrollment form, this means you will not get any financial help lowering your monthly premium or out-of-pocket costs like deductibles, copayments, and coinsurance. To see the Presbyterian On Exchange plans and to see if you qualify for these savings, visit www.bewellnm.com or call 1-833-862-3935.

Return Information			
By Fax: (505) 923-8252		By Mail: Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125-7489	
STEP 1: Tell us about yourself.			
We will need one adult in the family to be the contact person for your application.			
First Name, Middle Initial, Last name and Suffix			
Physical Address (required – P.O. Boxes are not allowed)			Apartment or Suite Number
City	State	ZIP Code	County
Mailing Address (if different from physical address)			Apartment or Suite Number
City	State	ZIP Code	County
Primary Phone	Secondary Phone	Do you want plan information by email? <input type="checkbox"/> Yes <input type="checkbox"/> No Email:	
Social Security Number (required)		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
Ethnicity: (Optional)		Race: (Optional)	
1. Do you need health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No, I am completing this form to enroll a dependent onto a child-only plan. Go to Step 2			

STEP 2: Now, tell us who else needs coverage.				
Name	Relation	Gender	Date of Birth	SSN
First Name, MI, Last Name	Spouse/Child	Male/Female	mm/dd/yyyy	required
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
If you have more dependents to include, make a copy of this page and attach.				

STEP 3: Effective Date Selection

- Open Enrollment** is November 1 through December 15. Coverage will begin on the first of the month following submission of your application.
- Special Enrollment** is available year-round.
 Please select: Next available Other month _____ within 60 days of this application
- You must enroll within 60 days of a qualifying life event to be eligible for coverage (i.e. loss of coverage, relocation with proof of prior coverage, marriage or gaining a dependent). Proof of a qualifying life event is required. The submission deadline is the last day of the month, coverage will begin on the first of the month following submission of your application.

STEP 4: Tell us what plan you would like to choose.

 Choose one plan:

Plan options for residents of Bernalillo, Sandoval, Valencia, Tarrant and Santa Fe Counties with the "Individual Select HMO" Network

Gold	Silver	Bronze
<input type="checkbox"/> Gold 1 <input type="checkbox"/> Gold 2 <input type="checkbox"/> Gold 4 <input type="checkbox"/> Gold+ with TytoHome	<input type="checkbox"/> Silver 3 <input type="checkbox"/> Silver 5	<input type="checkbox"/> Bronze 1

Plan options for residents of any New Mexico County with the "Individual and Family or Group HMO/POS" Network

Gold	Silver	Bronze
<input type="checkbox"/> Gold 3	<input type="checkbox"/> Silver 1 <input type="checkbox"/> Silver 2 <input type="checkbox"/> Silver 6	<input type="checkbox"/> Bronze 2

 View the network and provider directory online at www.phs.org/directory.

STEP 5: Health Savings Account (HSA)

Silver 1 and Silver 2 is/are Qualified High Deductible Health Plans (HDHP) that can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with Health Equity, you can open an HSA to pay for your insurance deductible and qualified out-of-pocket expenses tax-free. To learn more, visit www.healthequity.com or call 1-866-346-5800.

- Yes**, I am enrolling on Silver 1 or Silver 2 and want to open an HSA account with Health Equity.

STEP 6: Tell us how you will pay your monthly premiums.

If you do not select a payment option, you will get a bill each month.

Please select one of the following options to make prepayments:

- Credit/Debit Card Automatic Bank Draft Bill Me

Credit/Debit Card

- MasterCard Visa Discover

Card Account Number _____ - _____ - _____ - _____

Name on Card _____ Card Expiration Date ___/___ CSV _____

Card Billing Address (address where you receive your card statements)

Street Address _____

City _____ State _____ Zip _____

Automatic Bank Draft

- Checking Account Savings Account

Name of Bank _____

Account Number _____ Routing Number _____

Name of Account Holder _____

STEP 7: Terms and Conditions

I understand this is not an on exchange plan. This means you won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance) if you enroll in this plan. To see if you qualify for these savings and to enroll in an on exchange plan, visit www.bewellnm.com or call 1-833-862-3935.

Presbyterian Health Plan, Inc. (PHP) insurance is prepaid health coverage. This means you pay your premium payment for coverage prior to the month of coverage. If you do not select a payment option, you will get a bill each month.

I hereby authorize and request PHP 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 enrolled individuals listed on this application. This authorization is to remain in effect until PHP and/or the financial institution(s) named above are notified in writing.

I understand applicants enrolled 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. I understand covered benefits, services, utilization management procedures, exclusions, and limitations are subject to the provisions of the Subscriber Agreement and/or Summary of Benefits Coverage. These documents may be found at www.phs.org/formsanddocuments or you may contact Presbyterian Customer Service Center by phone at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7 a.m. to 6 p.m. TTY users please call 711.

(continued on next page)

STEP 7: Terms and Conditions (continued)

I understand this policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the New Mexico Health Insurance Exchange (BeWellnm) at 1-833-862-3935 or www.bewellnm.com if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

I hereby authorize 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 or its designees for any permitted purpose. Purposes include, but are not limited to, evaluating my application for insurance, quality assurance, utilization review, processing of claims, financial audits, or other purposes related to the treatment, payment, or healthcare operations activities of PHP. This consent shall not permit the use or disclosure of PHI when authorization is required by law. 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. Notices of Privacy Practices can be found online at www.phs.org/Pages/privacy-security.aspx. This authorization shall be valid for two years from this date and you have the right to revoke this authorization at any time by sending written notice to Presbyterian.

I understand that if I am enrolling on the Gold+ with TytoHome plan, TytoCare™ will share aggregated data on usage of the devices. The data will be de-identified before it is shared and will later be compared against claims data. I understand and agree to this data sharing. Receiving this device will not affect my coverage with Presbyterian. By submitting this form, I agree to receive product messages from TytoCare via your email and phone number. Message and data rates may apply. View the TytoCare™ [terms of service](#) and [privacy policy](#).

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 HEALTH PLAN, 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 form in its entirety.

Signature of Applicant or Legal Guardian

Today's Date*

x _____

*Application will expire 60 days from the date of your signature.

Agents and Brokers Information

First Name, Middle Name, Last Name and Suffix

Phone Number

Organization Name

National Producer Number (NPN)