PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

# Employer Group Information Application

## Application Instructions

1. Get help with this application by calling us at (505) 923-5807 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m. Additional forms may be found online at www.phs.org/employers.
2. Complete this form and fax it to (505) 923-8225 or email it to your account executive.

## Step 1 – Employer Group Information

### Requested effective date:

| | | | |
|---|---|---|---|
| Group name: | | Tax identification number: | |
| Group legal name (if different then above): | | | |
| Group contact name: | Group contact title: | Billing contact name and title: | Billing contact title: |
| Group contact phone: | | Billing contact phone: | |
| Group contact email: | | Billing contact email: | |
| Physical address (P.O. Boxes are not allowed): | | Suite number: | |
| City: | State: | ZIP code: | County: |
| Billing address (if different from physical address): | | Suite number: | |
| City: | State: | ZIP code: | County: |

Is this company affiliated with any other companies? Yes ☐ No ☐ If yes, affiliation's name:

Was group previously enrolled with Presbyterian? Yes ☐ No ☐ If yes, group name/number:

## Step 2 – Eligibility and Contribution Guidelines

**Waiting Period:**

☐ Date of hire

☐ 1st of the month following date of hire

☐ 1st of the month following 30 days of employment

☐ 1st of the month following 60 days of employment

☐ Effective on the 91st date of employment

**Eligibility:**

1. Part-time employment applies to waiting period? Yes ☐ No ☐
2. Group agrees to domestic partner coverage?
   Yes ☐ No ☐
3. Group is COBRA eligible? Yes ☐ No ☐
   If Yes, COBRA Administrator Name
   _____
4. Offering a qualified high deductible plan?
   Yes ☐ No ☐ If Yes, HealthEquity HSA through Presbyterian? Yes ☐ No ☐
   If yes, complete the HealthEquity enrollment forms.
5. Does employer wish to waive the waiting period for initial enrollment? Yes ☐ No ☐

## Premium Contributions

Employee: _____% or $_____ Spouse: _____% or $_____ Dependents: _____% or $_____

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## Step 3 – Group Census

☐ Group attests they have 50 or less full-time equivalent employees based on IRS guidelines. Use the full-time equivalent employee (FTE) calculator online at https://www.healthcare.gov/shop-calculators-fte to verify your FTE count.

| | | |
|---|---|---|
| Total employees: | = | |
| # of part-time or seasonal employees: | - | |
| # of employees in the waiting period | - | |
| # of eligible employees (including waivers): | = | |
| # of employee with other coverage waiving coverage: | - | |
| # of employee without other coverage waiving coverage: | - | |
| Total # of employees enrolling: | = | |
| Total # of employees living and/or working outside of New Mexico: | | |

## Step 4 – Medical Plan Selection

You may choose 1- 3 plans between HMO, PPO, and Engage. HMO and Engage plans underwritten by Presbyterian Health Plan, Inc. PPO plans underwritten by Presbyterian Insurance Company, Inc.
All plans are offered on and off exchange.

**☐ HMO Plans**

| Platinum Plan | Gold Plans | Silver Plans | Bronze Plans |
|---|---|---|---|
| ☐ Platinum 1<br>☐ Platinum 2 | ☐ Gold 2<br>☐ Gold 3<br>☐ Gold 4 | ☐ Silver 1<br>☐ Silver 3<br>☐ Silver 4<br>☐ Silver 8 | ☐ Bronze 1 |

**☐ PPO Plans**

| Platinum Plan | Gold Plans | Silver Plans | Bronze Plans |
|---|---|---|---|
| ☐ Platinum 1<br>☐ Platinum 2 | ☐ Gold 1<br>☐ Gold 2<br>☐ Gold 3<br>☐ Gold 4 | ☐ Silver 1<br>☐ Silver 3<br>☐ Silver 4<br>☐ Silver 8 | ☐ Bronze 1 |

**☐ Engage Plans**

| Platinum Plan | Gold Plans | Silver Plans | Bronze Plans |
|---|---|---|---|
| ☐ Platinum 3 | ☐ Gold 1<br>☐ Gold 5 | ☐ Silver 5<br>☐ Silver 6<br>☐ Silver 7<br>☐ Silver 9 | |

## Step 5 – Dental and Vision Plan Selection

Available for groups with two or more enrolling.

**DentalSource Dental Plan ☐ Yes ☐ No**
If yes, please complete the *separate* **DentalSource Employer Application** and select the High or Standard Option. (*Dental coverage is underwritten and administered by Companion Life Insurance Company)*

**Vision Buy-Up Plan Options ☐ Yes ☐ No**
If yes, please choose plan:
☐ Vision Plus
☐ Vision Premier
☐ Vision Premier Plus
*(These riders are available for all small groups to cover adults age 19 and above. Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. (Administered by Davis Vision)*

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## Step 6 – Payment Information

Select a payment option (automatic bank draft or bill me)

☐ Checking account ☐ Savings account ☐ Bill me (for groups with 10+ employees enrolled only)
Must include 1st months premium payment with application

| Name of bank: | Name of account holder: |
|---|---|
| Routing number: | Account number: |

## Step 7 – Authorizations and Agreements

I hereby authorize and request Presbyterian to initiate and withdraw entries from the account indicated and the financial institution named for monthly premium payments required by the Group Subscriber Agreement/Summary Plan Description. This authorization is to remain in effect until Presbyterian and the financial institution named are notified in writing. I understand that I have the right to terminate this agreement by notifying my financial institution. However, I understand that prearranged withdrawal entries are the required method of premium payment under the Group Subscriber Agreement/Summary Plan Description.

I understand that if I am enrolling on the Silver 8 and/or Silver 9 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 acknowledge that I have read and understand this application in its entirety.

**Signature of group contact**

X_____ Date: _____

**Signature of billing contact**

X_____ Date: _____

## Agent and Broker Information

| First and last name: | Phone number: |
|---|---|
| Agency name: | NPN number: |



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