

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call Presbyterian Medicare Sales at **(505) 923-8458** or **1-800-347-4766**. TTY users can call 711.

Understanding the Benefits

- The Evidence of Coverage (EOC), provides a complete list of coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **www.phs.org/medicare** or call **(505) 923-8458** or **1-800-347-4766**, TTY users can call 711, to view a copy of the EOC.
- Review the provider directory (or ask your provider) to make sure the providers you see now are in the network. If they are not listed, it means you will likely have to select a new provider.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (providers who are not listed in the provider directory).
- Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information.

**Presbyterian Senior Care (HMO) Extra Health Plan
2026 Individual Enrollment Request Form**

Who can use this form?

People with Medicare who want to join a Medicare Advantage plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the United States
- Live in the plan’s service area

Important: To join a Medicare Advantage plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- If your plan has a premium, your plan will send you a bill for the plan’s premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Complete and sign your form and send it to us using one of the options below:

Mail: Presbyterian Health Plan, Inc.
P.O. Box 27489
Albuquerque, NM 87125-7489

Fax: (505) 923-5385

Online: pchs.org/medicare

Once we process your request to join, we’ll contact you.

When do I use this form?

You can join a plan:

- Between October 15 to December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you’re allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

How do I get help with this form?

Call Presbyterian Medicare Sales at **(505) 923-8458** or **1-800-347-4766**. TTY users can call **711**. Or call Medicare at **1-800-MEDICARE (1-800-633- 4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a Presbyterian Medicare Sales al **(505) 923-8458** o **1-800-347-4766/TTY 711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional— you can’t be denied coverage because you don’t fill them out.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g. social security checks) may be considered your permanent residence address.

**Presbyterian Senior Care (HMO) Extra Health Plan
2026 Individual Enrollment Request Form**

Section 1 – All fields on this page are required (unless marked optional)

SELECT THE PLAN YOU WANT TO JOIN:

Part D Drug coverage is included:

Presbyterian Senior Care (HMO) Extra Health Plan with Rx - \$0 per month.

Presbyterian Senior Care (HMO) Plans are available in these counties:
Bernalillo, Cibola, Rio Arriba, Sandoval, Santa Fe, Socorro, Torrance, and Valencia.

Optional Supplemental Benefit:

Comprehensive Dental - \$29.30 per month

FIRST Name: _____ LAST Name: _____ Middle Initial: (Optional) _____

Birth Date: (M M / D D / Y Y Y Y) (__ / __ / ____)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number: (Cell Preferred) ()	Email:
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Permanent Residence Street Address (Don't enter a P.O. Box):

City:	County:	State:	ZIP Code:
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Mailing Address, if different from your permanent address (P.O. Box allowed):

City:	State:	ZIP Code:
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Your Medicare information:

Medicare Number: _____ - _____ - _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Presbyterian Senior Care (HMO)? Yes No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

**Presbyterian Senior Care (HMO) Extra Health Plan
2026 Individual Enrollment Request Form**

IMPORTANT – Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Presbyterian Senior Care (HMO).
- By joining this Medicare Advantage (MA) plan, I acknowledge that Presbyterian Senior Care (HMO) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for Private Fee-For-Service (PFFS), MA Medical Savings Account (MSA) plans).
- I understand that Presbyterian Senior Care (HMO) has worldwide emergency/urgent care services.
- I understand that when my Presbyterian Senior Care (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Presbyterian Senior Care (HMO). Benefits and services provided by Presbyterian Senior Care (HMO) and contained in my Presbyterian Senior Care (HMO) “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Presbyterian Senior Care (HMO) will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under state law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature:

Today's Date:

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone Number:

Relationship to Enrollee:

For individuals helping enrollee with completing this form only:

Name:

Relationship to Enrollee:

Signature:

National Producer Number (agent/Brokers only):

How was enrollment received: Walk-in with presentation In Home with presentation
 Seminar/Meeting Telephonic Walk-in without presentation
 In Home without presentation Mail in Email Faxed

Plan ID# _____ Effective date of coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

**Presbyterian Senior Care (HMO) Extra Health Plan
2026 Individual Enrollment Request Form**

Section 2 – All fields on this page are optional Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

I may need help accessing care or benefits and would like to be contacted (check all that apply):

- Find a new primary care provider (PCP)
- Transfer prescription/medication (e.g., coverage, cost, mail order)
- Care coordination (for example, if you have complex healthcare needs)

Select one if you want us to send you information in a language other than English.

- Spanish Other _____

Select one if you want us to send you information in an accessible format.

- Braille Large Print Audio CD Data CD

All materials are available in Spanish and a machine-readable format through our website or by request. Please contact Presbyterian Customer Service Center at **(505) 923-6060** or **1-800-797-5343** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711.

Do you work? Yes No

Does your spouse work? Yes No

List your primary care provider (PCP), clinic or health center:

As part of your enrollment, do you want to receive any of the following materials via email?

- Plan Formulary Summary of Benefits Evidence of Coverage

**Presbyterian Senior Care (HMO) Extra Health Plan
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Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)," or credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. Please select a payment option:

- Get a bill.

- Electronic Funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Saving

- Credit Card. Please provide the following information:
Type of Card: Visa MasterCard Discover
Name of Account holder as it appears on card: _____
Account number: _____ Expiration Date: __ / ____ (MM/YYYY)

- Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: Social Security RRB

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay Presbyterian the Part D-IRMAA.

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.

SHOOH: Diné bee yánitfi'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'j' ahoot'i'ígíí éí t'áá jik'eh hóló. Kohji' 1-855-592-7737 (TTY: 711) hodílinih doodago nika'análwo'í bich'j' hanidziih.

For more information, visit <https://www.phs.org/nondiscrimination>.

Notice of Availability

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.
Navajo Diné	SHOOH: Diné bee yániffti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiiik'eh ná hóló. Bee ahit hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'j' ahoot'i'ígíí éí t'áá jiiik'eh hóló. Kohji' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'j' hanidziih.
Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-592-7737 (Người khuyết tật: TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-592-7737 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Chinese Simplified 简体中文	注意：如果您使用简体中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以提供无障碍格式版信息。请拨打 1-855-592-7737 (TTY: 711) 或咨询您的服务提供者。
Chinese Traditional 繁體中文	注意：如果您使用繁體中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服务，以提供無障礙格式版資訊。請致電 1-855-592-7737 (TTY:711) 或諮詢您的服務提供者。
Japanese 日本語	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-592-7737 (TTY:711) までお電話ください。または、ご利用の事業者にご相談ください。
Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.

French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (TTY: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. و متاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DiKKATİNiZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.