PRESBYTERIAN

Presbyterian Senior Care (HMO)

2026 COMPREHENSIVE DENTAL PLAN ENROLLMENT FORM

Your plan already includes a Basic Dental Plan for preventive services at no cost to you.

Please complete this form to **add** the optional Comprehensive Dental Plan for:

- $29.30 per month for Presbyterian Senior Care plans (HMO)

Your coverage will start the first day of the month following the date your form is received by Presbyterian.

Member last name, first name, middle initial:		Date:
Date of birth:	Member number:	Phone number:

PAYING YOUR DENTAL PREMIUM

Please select a premium payment option:

The premium for the Comprehensive Dental Plan will be added to your monthly medical plan premium. Both your dental and your medical plan premiums need to be paid with the same payment option.

If you don't select a payment option, your dental premium will be paid with the same payment option we have on file for your medical plan, excluding Social Security (SSA) premium withhold. If we don't have a payment option currently on file, you will get a bill each month.

Please note: If you would like to choose Electronic Funds Transfer or credit card but do not want to provide your payment information on this form, please call our Presbyterian Customer Service Center at the phone number on the back of your ID card **after your effective date** to set up the payment.

☐ **Electronic Funds Transfer** (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account type: ☐ Checking ☐ Savings	Account holder name:
Bank routing number:	Bank account number:

☐ **Credit Card** ☐ Visa ☐ MasterCard ☐ Discover	Expiration date:
Account holder name as it appears on card:	Account number:

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

The Social Security deduction may take two or more months to begin after Social Security or RRB accepts your request for automatic deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB doesn't approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

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ACKNOWLEDGEMENT	
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:

Please mail or fax the completed form to:

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

Fax:
(505) 923-5385
Attn: Enrollment

Office Use Only:

Name of staff member/agent/broker: _____

Broker NPN: _____

Did staff member educate/assist in enrollment: ☐ Yes ☐ No

☐ Telephonic Date/Time:_____ Confirmation number: _____

☐ In person Date/Time: _____ Method: ☐ Drop off ☐ ANOC ☐ Sales Seminar

Effective Date of Coverage:_____