Employer Group Information Application

PRESBYTERIAN

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

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 (MM/DD/YYYY):

Group name:		Tax identification number:	
Group legal name (if different than above):			
Group contact name:	Group contact title:	Billing contact name:	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

☐ First of the month following date of hire

☐ First of the month following 30 days of employment

☐ First of the month following 60 days of employment

☐ Effective on the 91st date of employment

Eligibility:

1. Part-time employment applies to the 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 $_____

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:	=	
Number of part-time or seasonal employees:	-	
Number of employees in the waiting period	-	
Number of eligible employees (including waivers):	=	
Number of employee with other coverage waiving coverage:	-	
Number of employee without other coverage waiving coverage:	-	
Total Number 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 Plans

Platinum Plan	Gold Plans	Silver Plans	Bronze Plans
☐ Platinum Elite w/Gym	☐ Gold Elite $1,000 w/Gym ☐ Gold Elite $2,500 w/Gym ☐ Gold Premier $3,500 w/Gym	☐ Silver $3,500 Advantage HDHP/HSA w/Gym ☐ Silver Premier $4,000 w/Gym	☐ Bronze Elite $10,150 w/Gym

☐ PPO Plans

Platinum Plan	Gold Plans	Silver Plans	Bronze Plans
☐ Platinum Elite $250 w/Gym	☐ Gold Elite $1,000 w/Gym ☐ Gold Elite $2,500 w/ Gym ☐ Gold Premier $3,500 w/Gym	☐ Silver $3,500 Advantage HDHP/HSA w/Gym ☐ Silver Premier $4,000 w/Gym	☐ Bronze Elite $10,150 w/Gym

☐ Engage Plans

Platinum Plan	Gold Plans	Silver Plans
☐ Platinum Engage $500 w/Gym with Limited Network	☐ Gold Engage $1,500 w/Gym Limited Network ☐ Gold Engage $3,500 w/Gym Limited Network	☐ Silver Engage $4,000 w/Gym limited Network ☐ Silver Engage $7,000 w/Gym limited Network ☐ Silver Engage $0 w/Gym limited Network ☐ Silver Virtual Plus Engage w/Gym with Limited Network

Step 5 – Dental and Vision Plan Selection

Available for groups with two or more enrolling.

BenefitSource Dental Plan Yes ☐ No ☐

If yes, please complete the ***separate*** **BenefitSource 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))

Step 6 – Payment Information		
Select a payment option (automatic bank draft or bill me). Must include first month's premium payment with application.		
☐ Checking account ☐ Savings account ☐ Credit Card* ☐ Bill me (for groups with 10+ employees enrolled only) *Discover, Visa, Master Card accepted.		
Name of bank:		Name of account holder:
Routing number:		Account number:
Name on Card:		Credit Card Number:
Expiration Date:	CSV:	Start Date of Payment:

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.

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:	National Provider Number:

For information on Presbyterian Health Plan's Nondiscrimination Notice, go to https://www.phs.org/nondiscrimination.