PRESBYTERIAN Health Plan, Inc.

INDIVIDUAL AND FAMILY PLAN – QUALIFYING EVENT OR MOVE DEPENDENT FORM

If you have questions please contact our Individual Plan Sales team at 505-923-8224 or toll-free at 1-866-869-7737 option 4, Monday through Friday from 8 a.m. to 5 p.m.

RETURN INFORMATION:	
By Fax: (505) 923-5888	By Mail: Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125-7489

SUBSCRIBER INFORMATION:

Primary Policy Holder's Name:	Subscriber ID Number:		Date of Birth:	Phone Number:
Address:	City/State:	ZIP:	E-mail:	

STEP 1 - QUALIFYING EVENTS FOR COVERAGE:

- Use this form to add or move dependents to or from your existing coverage.
- If adding a dependent, you need to have one of the qualifying events listed below. The qualifying event must be within the last 60 days. Proof of your qualifying event (e.g. birth certificate, marriage certificate) is **required** to process your request.

Add Dependent(s) – Check ☑ one box:	Move Dependent(s):
☐ Birth, Adoption or Placement of a Child ☐ Child support order or other court order ☐ Marriage with proof of prior qualifying health coverage ☐ Loss of Coverage ☐ Gaining U.S. citizenship ☐ Relocation with proof of prior qualifying health coverage	☐ Move a dependent to a separate policy with the same benefit plan and select a payment option below: ☐ Existing Bank or Credit Card authorization on file ☐ New Bank or Credit Card authorization. If "new" please complete a Bank Authorization Form which can be found online at www.phs.org/formsanddocuments. ☐ Or receive your monthly premium bill by mail

STEP 2 - DEPENDENT INFORMATION: Only your spouse and eligible dependent children under age 26 may be included in this section. If you have more dependents to include, please make a copy of this page and attach.

Add or Move	Name First, MI, Last	SSN	DOB	Gender	Relationship	Requested Effective Date

If moving a dependent to a separate policy, please provide new address, phone number and email information here (if applicable):

I **understand** that I am entitled to a copy of this signed form upon request.
I **acknowledge** that I have read the other side of this form and understand this form in its entirety.

Print Name of Primary Policy Holder (Or Legal Guardian if Applicant is a Minor)	X Signature of Primary Policy Holder *(Required)* (Or Legal Guardian if Applicant is a Minor)	Today's Date
Print Name of Applicant's Spouse If applying	X Signature of Applicant's Spouse *(Required)* If applying	Today's Date
Print Name of Applicant's Dependent If applying and over 18	X Signature of Applicant's Dependent *(Required)* If applying and over 18	Today's Date
Print Name of Applicant's Dependent If applying and over 18	X Signature of Applicant's Dependent *(Required)* If applying and over 18	Today's Date

AUTHORIZATIONS AND ACKNOWLEDGEMENTS:

Presbyterian Health Plan, Inc. determines actual effective dates. Your requested effective date is not guaranteed. If your request is received by the last day of the month your effective date will be the first of the following month. Exceptions: Newborns, newly adopted child or a child for whom a Subscriber becomes a legal guardian, the effective date will be the date of birth, date of placement, or the court order granting guardianship.

If automatic premium draft was selected, I hereby authorize and request Presbyterian Health Plan, Inc. (PHP) to continue to withdrawal entries from the account(s) and the financial institution(s) on file for the monthly premium payments required by the Subscriber Agreement. This authorization is to remain in effect until PHP and/or the financial institution(s) are notified in writing.

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 7:00 a.m. to 6:00 p.m. TTY users please call: Relay 711.

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 at www.nmhix.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 including, but 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 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.

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.