

To save time, you can apply for coverage on-line at www.phs.org

Instructions

1. As the applicant, please complete all sections of this Application, date and sign. You are responsible for the accuracy and completeness of all information entered on this form. If completing for minor child(ren), a legal guardian must complete, sign and date this Application. This Application must be completed in ink.
2. Please do not remit a premium payment with this Application. All questions must be answered in full. Full disclosure is essential in quickly processing your application; missing information may result in delays and/or declination.
3. If you have a Certificate of Creditable Coverage, please attach a copy and submit with this Application.
4. Your effective date must be within 60 days of this Application and be either the first or fifteenth of the month. For example, if you submit your application on 1/25/2007, your effective date choices are 2/15/2007, 3/1/2007, or 3/15/2007.

Get a Quote (Information needed to quote the benefit plan right for you)

I am applying for coverage for:	Effective Date Selection (must be within 60 days of the date of this Application):	
Self	First of the Month of: _____	Fifteenth of the Month of: _____
Self & Spouse	If above date cannot be met, what alternate date would you prefer:	
Self & Child(ren)	First of the month only	
Self & Family	Fifteenth of the month only	
My Child(ren) Only	Next available effective date, to include the first or the fifteenth of the month	

Applicant and Dependent Information

List only those individuals below who are applying for coverage. If applicant is self, your legal dependents include your lawful spouse, and your unmarried child(ren), step child(ren), or adopted child(ren) who are under age 25. Children that are 25 or older must complete their own Application. If applying for child only coverage with multiple children, please list oldest child as applicant and all other children under the Legal Dependent/Child areas below. Please list what Tobacco products the applicant has used, if any, in the last 24 months in the last column.

Last Name	First Name	M.I.	Relationship	Gender/ Sex	Date of Birth	Social Security #	Height (in feet and inches)	Weight (in lbs.)	Used Tobacco in last 24 months
			Self	<input type="checkbox"/> Male <input type="checkbox"/> Female					
			Legal Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female					
			Dependent/ Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					
			Dependent/ Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					
			Dependent/ Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					
			Dependent/ Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					

If applying for child(ren) only, please complete this section.

If not a parent or adoptive parent, please indicate relationship(s) of person completing this Application to each child applicant:

Legal Guardian Trustee Other, please describe: _____

By entering this information, you warrant and represent that you have the legal status entered above and have the authority to act on behalf of each child applicant. You also understand and agree that failure to provide supporting documentation may result in a denial or retroactive termination of coverage).

Your Name: _____ Your Date of Birth _____

Please indicate which benefit plan you are applying for:

PresMetro Plans

(Available only in Bernalillo, Sandoval, Torrance and Valencia Counties, including Edgewood)

All PresMetro plans include standard Dental & Vision Benefits	Prescription Drug Buy-Down Options		
\$500 – 80/20 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$750 – 80/20 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$1,000 – 80/20 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$2,000 – 80/20 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$5,000 – 80/20 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit

Dental Enhancement Benefit Option (additional monthly premium) :

Maternity Riders are available with this product; if electing a maternity benefit, please indicate your selection below:

0/50/100% \$2,500 maximum benefit Maternity Rider	0/50/100% \$4,000 maximum benefit Maternity Rider
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PresSolo Plans

All PresSolo plans include standard Dental & Vision Benefits	Prescription Drug Buy-Down Options		
\$500 – 70/30 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$750 – 70/30 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$1,000 – 70/30 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$2,000 – 70/30 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit
\$5,000 – 70/30 Plan w/ \$10/35/75 Rx		\$0/10 generic drugs only	No Rx benefit

Dental Enhancement Benefit Option (additional monthly premium) :

Maternity Riders are available with this product; if electing a maternity benefit, please indicate your selection below:

0/50/100% \$2,500 maximum benefit Maternity Rider	0/50/100% \$4,000 maximum benefit Maternity Rider
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Advantage Care Plans

(HSA qualified High Deductible Health Plans – No Pharmacy on Standard Plan)

(Available in all counties in New Mexico, except Eddy and Lea counties)

\$1,200 - 80/20 Plan 1 member enrolling \$1200 deductible 2 or more members enrolling \$2,400 deductible	\$5,000 - 80/20 Plan 1 member enrolling \$5,000 deductible 2 or more members enrolling \$10,000 deductible
\$2,500 - 80/20 Plan 1 member enrolling \$2,500 deductible 2 or more members enrolling \$5,000 deductible	Add the 20/20/30% Prescription Rider to my Advantage Plan <input type="checkbox"/> Yes <input type="checkbox"/> No

If any one applicant is denied coverage, do you wish to cover the remaining applicants? Yes No

About You

Applicant Information – (If applying for child(ren) coverage only, list oldest child information in this section.)

New enrollment Re-apply

Last Name:	First Name:	M.I.	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Social Security #
Physical Address (include Apt. # if applicable – No P.O. Boxes):				
City:	State:	Zip Code:	County:	
Home Phone:		Work Phone/Message Phone:		
E-Mail Address:				

Mailing address if different from physical address

Mailing Address (include Apt. # if applicable):

City:	State:	Zip Code:	County:
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General Information

1. Where did you hear about Presbyterian's Individual Plan? <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Billboard <input type="checkbox"/> Newspaper <input type="checkbox"/> Direct Mail <input type="checkbox"/> My Doctor <input type="checkbox"/> My Broker <input type="checkbox"/> Other: _____ If "Direct Mail," please provide the promotional code located on the lower right corner of the card:	
2. Are all individuals applying for coverage on this Application New Mexico residents, living in New Mexico at least 6 months each year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Employer's Name _____ Hire Date: ____/____/____	
4. Have you or any applying dependents ever been a member of Presbyterian Health Plan or Presbyterian Insurance Company? If "yes," please specify applicant(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you or any applying dependents currently have health insurance coverage? If "yes," please provide details on which applicant(s), their insurance carrier name, policy numbers, and coverage dates. Name of person(s) covered: _____ Type of coverage: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Other (specify): _____ Current Carrier Name(s) and Policy Number(s): _____ Date(s) coverage began: __/__/__, __/__/__, __/__/__ <i>If you or another applicant has group coverage, do you plan on keeping this coverage?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If you answered "yes" to the question above because you or another applicant has group coverage, you are not eligible to apply unless you meet one of the following criteria:</i> 1. You are applying for coverage for your dependent(s) only. 2. You will be terminating from your employment prior to the requested effective date of this policy. 3. There will be a change in your employment status (i.e. moving from full-time to part-time) which will make you ineligible for benefits through your employer.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you or any applying dependents require any assistance due to a disability? If "yes," please provide the names of the person(s) and their % of disability. Please specify if the person(s) are enrolled in Medicare due to their disability: Applicant(s): _____ % Disability: _____ Details: _____ Enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you or any applying dependents eligible for Medicare or enrolled in Medicare? If "yes," please provide name of applicant(s): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you or any applying dependents had claims in excess of \$5,000 during the past twelve (12) months? If "yes," please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you or any applying dependents been denied health insurance coverage in the past (6) six months? If "yes," name of person: _____ Name of insurance company: _____ Details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you or any applying dependents speak a language other than English? If "yes," please list: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

All questions must be answered Yes or No. Incomplete Applications will be returned to you for completion, which will delay the processing of your Application.

Medical Questionnaire

Within the past **five (5) years** or as indicated within each medical question, have you or any applying dependents ever had signs or symptoms, or been told to have, or been treated or diagnosed with a condition for which consultation was or will be sought for any of the conditions below? **Check Yes or No to ALL questions.**

Please explain and provide the full details for each “Yes” answer to any condition(s) checked in the following boxes. (Attach additional sheets if necessary). Include for whom (self, spouse, child name) diagnosis, date of diagnosis, date of last treatment, and indicate if condition is mild or moderate or severe and indicate if condition is ongoing, and list any medications with dosages.

Example:

Q#	Name (self or dependent)	Date Treatment Began Ended *	Treatment Rendered (Tx) Current Status (Recovered or still in Treatment)	Name of Prescription (Rx) Are you still taking?	Additional details
3	Jane Doe	Began: May 1999	Tx: Inhaler Prescribed	Rx: Entex 1 tablet p/day	Mild Bronchitis
		Ended: ongoing	Recovered? Yes x No <input type="checkbox"/>	Still taking? X Yes <input type="checkbox"/> No	

Note: If treatment has ended, please indicate date; if treatment has not ended, please indicate “ongoing.”

1. AIDS or HIV+ List all applicants to whom the condition applies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Alcoholism (in lifetime): List all applicants to whom the condition applies: _____ Does any applicant currently consume 4 or more alcoholic beverages a day? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Allergies Has an applicant taken a prescribed medication in the past year and/or are receiving immunotherapy injections? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____ If receiving immunotherapy injections, indicate how often: <input type="checkbox"/> 1 – 2 times per year <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly/weekly If you do not receive immunotherapy injections, do you take seasonal prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for a duration of: <input type="checkbox"/> less than 5 year <input type="checkbox"/> more than 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Arthritis If “Yes,” have you required medication for pain relief? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____ Do you have osteoarthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____ If “yes” to osteoarthritis, medication is required for pain relief of symptoms which are considered <input type="checkbox"/> Mild or <input type="checkbox"/> Moderate to Severe Prescribed Medication: Please provide name(s) of applicant(s) and details of medications: _____ Do you have rheumatoid arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Asthma List all applicants to whom the condition applies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>Do(es) the applicant(s) with asthma smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are symptoms:</p> <p><input type="checkbox"/> Mild or Seasonal? Since initial treatment/diagnosis: <input type="checkbox"/> less than 2 yrs <input type="checkbox"/> 2 – 4 yrs <input type="checkbox"/> 4+ yrs</p> <p><input type="checkbox"/> Moderate? Since initial treatment/diagnosis: <input type="checkbox"/> less than 2 yrs <input type="checkbox"/> 2 – 4 yrs <input type="checkbox"/> 4+ yrs</p> <p><input type="checkbox"/> Severe?</p> <p>What medications are prescribed for asthma? (please provide name(s) of applicant(s) and details of medications): _____</p>	
<p>6. Backache, sprain or strain</p> <p>All fields need to be completed for each individual with the “Yes” response.</p> <p>Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Blood disorder including coagulation defect, hemophilia, polycythemia vera, sickle cell anemia or thrombocytopenia purpura (bleeding disorder)</p> <p>List all applicants to whom the condition applies: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Cancer or other malignancy including leukemia, lymphoma, myeloma (in lifetime)</p> <p>List all applicants to whom the condition applies: _____</p> <p>Was basal or squamous skin cancer the only form of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Other form of cancer</p> <p>Select all that applies to basal or squamous cell skin cancer.</p> <p><input type="checkbox"/> Untreated</p> <p><input type="checkbox"/> Treated</p> <p><input type="checkbox"/> Treated with one or more additional previous excision</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Abnormal pap or cervical dysplasia [only requires a response from female applicants]</p> <p>All fields need to be completed for each individual with a “Yes” response.</p> <p>Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If cervical dysplasia, indicate type: <input type="checkbox"/> Atypical squamous cell</p> <p style="padding-left: 40px;"><input type="checkbox"/> Squamous cell, Low Grade</p> <p style="padding-left: 40px;"><input type="checkbox"/> Squamous cell, High Grade</p> <p style="padding-left: 40px;"><input type="checkbox"/> Glandular cell</p> <p>How much time has elapsed since your pap tests have been normal? _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. Connective tissue disease including systemic lupus, polymyositis, psoriatic arthritis, Reiter’s, rheumatoid arthritis, scleroderma or Sjogren’s?</p> <p>List all applicants to whom the condition applies: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>11. Cyst, benign</p> <p>All fields need to be completed for each individual with a “Yes” response:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Name(s): _____ Treatment Date Began: _____ Ended: _____ Condition, Treatment Current status: _____ Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: <input type="checkbox"/> Bakers <input type="checkbox"/> Sebaceous <input type="checkbox"/> Barthoin's <input type="checkbox"/> Dentigerous <input type="checkbox"/> Nabothian Location on body? _____	
12. Disk or disease of the spine <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated or ruptured? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____ Select all which apply to applicant(s) who have undergone surgery: <input type="checkbox"/> Issue resolved, no current treatment or pain relief medication required. Number of years since treatment: <input type="checkbox"/> Less than 2 years <input type="checkbox"/> Between 2 to 5 years <input type="checkbox"/> For more than 5 years <input type="checkbox"/> Continues to require treatment and/or pain relief medication Degenerative? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____ Select all which apply to applicant(s) who have a degenerative condition: <input type="checkbox"/> No treatment or pain relief medication required <input type="checkbox"/> Physical therapy, chiropractic care or other forms of treatment required in the past 6 months equal up to 3 visits <input type="checkbox"/> Physical therapy, chiropractic care or other forms of treatment required in the past 6 months equal more than 3 visits	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Diabetes (excluding gestational diabetes over a year ago) List all applicants to whom the condition applies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Ear, nose, or throat including deviated septum, otitis media, Meniere's, sinusitis, tonsillitis or vertigo All fields need to be completed for each individual with a "Yes" response: Name(s): _____ Treatment Date Began: _____ Ended: _____ Condition, Treatment Current status: _____ Medication, Frequency, Dosage: _____ Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>15. Endocrine or thyroid disorder including Addison's disease, graves, goiter, or Hashimoto's. List all applicants who respond "Yes" to Addison's disease or hyperparathyroidism:</p> <hr/> <p>If "Yes" for other conditions, provide details for each individual with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>16. Eye disorders</p> <p>Macular degeneration? List all applicants to whom the condition applies: _____</p> <p>Cataract, detached retina, keratoconus or strabismus? List all applicants to whom the condition applies: _____</p> <p>Select all for applicants who have undergone a surgical procedure for this condition: Check which applies to cataract: Operated (with or without intraocular lens): <input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 6 months to 2 years <input type="checkbox"/> More than 2 years ago</p> <p>Check which applies to keratoconus: Operated: <input type="checkbox"/> Less than 2 years ago <input type="checkbox"/> More than 2 years ago</p> <p>Check which applies to stabismus: Operated: <input type="checkbox"/> Less than 2 years ago <input type="checkbox"/> More than 2 years ago</p> <p>Check which applies to detached retina (due to injury): Operated, normal vision: <input type="checkbox"/> Less than 2 years ago <input type="checkbox"/> More than 2 years ago</p> <p>Glaucoma? List all applicants to whom the condition applies: _____</p> <p>Check which applies: <input type="checkbox"/> Unoperated and Controlled with medication: <input type="checkbox"/> 1 to 2 yrs since diagnosis or treatment <input type="checkbox"/> More than 2 yrs since diagnosis or treatment <input type="checkbox"/> Surgery or laser treatment anticipated <input type="checkbox"/> Operated but medication required (1 to 2 yrs since diagnosis or treatment) <input type="checkbox"/> <input type="checkbox"/> Operated but controlled without medication <input type="checkbox"/> 1 to 3 yrs since diagnosis or treatment <input type="checkbox"/> More than 3 years since surgery</p> <p>Prescribed Medications (please provide name(s) of applicant(s) and details of medications): _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>17. Fibroid, uterine [only requires a response from female applicants] List all applicants to whom the condition applies: _____</p> <p>All fields need to be completed for each individual with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>18. Fracture or joint replacement (in lifetime) List all applicants to whom a “Yes” response would apply: _____</p> <p>Total joint replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the above does not apply or your response was “No,” please provide information for each individual with a “No” response. Name(s): _____</p> <p>Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>19. Gastrointestinal disorder including Crohn’s, esophageal reflux, esophagitis, diverticulitis, gastritis, hemorrhoids, hiatal hernia, irritable bowel syndrome, pancreatitis, peptic ulcer disease, ulcerative colitis (in lifetime)</p> <p>List all applicants to whom a “Yes” response would apply for ulcerative colitis, Crohn’s, or pancreatitis: _____</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>20. Genitourinary (urinary organs, including kidneys and the reproductive organs) Female disease including chronic cystitis, excessive uterine bleeding, endometriosis, or incontinence Male disease including enlarged prostate List all applicants to whom the condition applies (PSA level over 4):</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>21. Heart disease including angina, coronary artery disease, cardiomyopathy, congestive heart failure, heart attack or a history of an angioplasty, cardiac bypass or pacemaker (ICD) (in lifetime, not just over the last 5 years) List all applicants to whom the condition applies: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>22. Hepatitis, liver disease/cirrhosis If "Yes" to liver disease/cirrhosis, list all applicants with a "Yes" response:</p> <p>If yes to hepatitis, provide details for every applicant with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type: <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type C</p> <p>Indicate if ALT test has been within normal limits in the past year. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>23. Hypertension or high cholesterol</p> <p>Hypertension? List all applicants to whom the condition applies: _____</p> <p>Select all which apply to applicant(s) who have this condition:</p> <p><input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> History of hospitalization for this condition (Less than 3 years ago)</p> <p>Does the applicant(s) currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking two (2) or more medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please provide name(s) of applicant(s) and details of medications: _____</p> <p>High cholesterol? Select all which apply to applicant(s) who have this condition:</p> <p><input type="checkbox"/> Was the applicant(s) last total cholesterol reading less than 200 milligrams/dL? <input type="checkbox"/> Was the applicant(s) last total cholesterol reading between 201 and 219 milligrams/dL? <input type="checkbox"/> Was the applicant(s) last total cholesterol reading between 220 and 239 milligrams/dL? <input type="checkbox"/> Was the applicant(s) last total cholesterol reading more than 240 milligrams/dL?</p> <p>Prescribed Medications: Please provide name(s) of applicant(s) and details of medications: _____ _____</p> <p>List LDL and HDL readings, if applicable: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>24. Infertility [only requires a response from female applicants between the ages of 20-45] List all applicants to whom the condition applies: _____</p> <p>All fields need to be completed for each individual with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>25. Kidney disease including chronic renal failure, glomerulonephritis, Nephrotic syndrome, or polycystic kidney (Refer to question 26 for kidney stone)</p> <p>List all applicants to whom the condition applies: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>26. Kidney stone</p> <p>List all applicants who had a kidney stone in the past year: _____</p> <p>Give details for each individual with a “Yes” response:</p> <ul style="list-style-type: none"> <input type="checkbox"/> One stone passed spontaneously more than 1 year ago <input type="checkbox"/> Two or more stones passed spontaneously more than 1 year ago <input type="checkbox"/> Lithotripsy required for removal of stone/stones 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>27. Mental health or eating disorder including anorexia nervosa, bipolar disorder, bulimia, major depression, obsessive-compulsive, post-traumatic stress or schizophrenia (in lifetime, not just over the last years)</p> <p>If “Yes” for bipolar disorder, bulimia, major depression or schizophrenia, list all applicants with a “Yes” response: _____</p> <p>If “Yes” for other mental health conditions listed, give details for each individual: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the applicant ever been hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>28. Migraines or chronic fatigue syndrome</p> <p>Chronic Fatigue Syndrome? List all applicants to whom the condition applies: _____</p> <p>Migraine? List all applicants to whom the condition applies: _____</p> <p>Please indicate for each applicant to whom the condition applies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Occasional mild attacks <input type="checkbox"/> 3 to 6 moderate attacks per year, multiple medication <input type="checkbox"/> 6 or more moderate attacks per year, multiple medication <p>Please provide name(s) of applicant(s) and details of medications: _____</p> <p>List all applicants who had one or more emergency room visits in the past two years: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>29. Musculoskeletal disorder including ALS(Amyotrophic Lateral Sclerosis), bursitis, bone spur, bunion, carpal tunnel, cruciate, fibromyalgia, gout, hammer toe, ligament injury, meniscus tear, muscular dystrophy, rotator cuff, spondylosis, spinal stenosis or tendonitis (indicate condition by circling)</p> <p>If “Yes” for ALS, fibromyalgia, muscular dystrophy, reflex sympathetic dystrophy, spondylosis or spinal stenosis, list all applicants with a “Yes” response: _____</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If “Yes” to gout, please indicate the average number of attacks per year: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>30. Neurological disorder including brain injury, Alzheimer's, Bell's palsy, cerebral palsy, epilepsy, Guillain-Barre', multiple sclerosis, myasthenia gravis, Parkinson's, or spinal cord injury List all applicants to whom the condition applies: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>31. Osteoporosis or osteopenia List all applicants under the age of 50 years to whom the condition applies: _____ List all applicants above the age of 50 years old to whom the condition applies: _____ Please indicate for each applicant to whom the condition applies: <input type="checkbox"/> Mild condition <input type="checkbox"/> Moderate condition <input type="checkbox"/> Severe condition Prescribed Medication: <input type="checkbox"/> Actonel, Fosamax <input type="checkbox"/> Boniva, Evista <input type="checkbox"/> Forteo Please provide name(s) of applicant(s) and details of other medications):</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>32. Pediatric disorders including congenital birth defects, cleft palate, Down syndrome, or cardiac defect List all applicants to whom the condition applies: _____ All fields need to be completed for each individual with a "Yes" response: Name(s): _____ Treatment Date Began: _____ Ended: _____ Condition, Treatment Current status: _____ Medication, Frequency, Dosage: _____ Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to cardiac defect, please indicate the specific diagnosis or condition:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>33. Polyp Vocal cord polyp? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies: _____ Nasal or gastrointestinal polyp? <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal polyp List all applicants to whom the condition applies: _____ Select all that applies to nasal polyp: <input type="checkbox"/> Operated and no recurrence of one or more polyps <input type="checkbox"/> Less than 3 years ago <input type="checkbox"/> More than 3 years ago <input type="checkbox"/> Operated and recurrence of one or more polyps <input type="checkbox"/> Not operated on Gastrointestinal or rectal polyp List all applicants to whom the condition applies: _____ Select all that applies to gastrointestinal or rectal polyp: <input type="checkbox"/> Operated and one operation with less than 4 polyps: <input type="checkbox"/> Less than 2 years ago <input type="checkbox"/> More than 2 years ago <input type="checkbox"/> Operated on and numerous or more than 4 polyps <input type="checkbox"/> Not operated on</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>34. Are any applicants currently pregnant or an expectant father? List all applicant to whom the condition applies: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>35. Pulmonary or respiratory disorder including bronchitis, chronic obstructive airway, cystic fibrosis, emphysema, pneumonia, pulmonary embolism or tuberculosis</p> <p>If “Yes” to chronic obstructive airway, cystic fibrosis, emphysema or pulmonary embolism, list all applicants with a “Yes” response:</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate if hospitalization was required: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>36. Have any applicants used illegal drugs and/or recreational drugs in the past 5 years?</p> <p>If “Yes” for conditions listed above, give details for each applicant with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate if hospitalization was required: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>37. Sexually transmitted disease including genital herpes or genital warts (HPV)</p> <p>If “Yes” for conditions listed above, give details for each applicant with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Specific diagnosis: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>38. Transplant (in lifetime, not just over the last 5 years)? List all applicants to whom the condition applies (excludes cornea transplant performed more than 12 months prior): _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>39. Vascular disease including aneurysm, stroke, blood clot, varicose veins, peripheral vascular disease, or Raynaud's If Yes to stroke or peripheral vascular disease, list all applicants with a "Yes" response:</p> <hr/> <p>If "Yes" for conditions listed above, give details for each applicant with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>40. Have any applicants been treated for, diagnosed, or advised on any other medical condition(s) that has not been addressed above?</p> <p>If "Yes" for conditions listed above, give details for each applicant with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>41. Have any applicants been told by a medical professional that medication or treatment may be needed in the future? If yes, provide details below. Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>42. Any hospitalizations or surgeries past or present not previously indicated? If yes, provide details below. Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>43. Are any applicants currently taking prescription medications (except for contraceptives to prevent pregnancy) not previously listed? If yes, provide details: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition or Diagnosis: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Payment Options

Proof of prior coverage (Required)

Important – Proof of coverage must be provided for pre-existing condition credit. A Certificate of Creditable Coverage from prior carrier/insurance company is an acceptable form of proof. Failure to provide proof of prior coverage may subject you or your family members to the full Pre-existing Condition limitation with no credit for prior coverage. You are entitled to a Certificate of Creditable Coverage from your prior carrier/insurance company. Pre-existing Conditions are diseases or conditions for which medical advice, diagnosis, care or treatment was recommended or received within the (6) six-month period before the individual's effective date on this plan.

Authorization Agreement for Prepayments (Presbyterian Insurance Company, Inc. – Individual Plans)

Approval for coverage does not constitute enrollment, when your first Prepayment has been deposited with Presbyterian, your coverage will become effective either on the first or the fifteenth of the month following approval, per your specified Effective Date Selection in Section I of this application.

Presbyterian Insurance Company, Inc. is pre-paid health coverage, which means you pay your prepayments for coverage prior to the month of coverage. Please select your preferred first prepayment and your subsequent prepayment choices by indicating with a check mark in the appropriate boxes below and then complete the corresponding financial information for both selections. When your first prepayment clears, your coverage will become effective either on the first or the fifteenth of the month following approval, per your specified Effective Date election. If you are accepted you will receive notification of the effective date of coverage, each individual approved for coverage and the amount that has been charged to your account. You may change the method of subsequent prepayments, however the effective date of the change will be dependent upon the time of month the request is made and the type of payment method requested.

Please select one of the following options to make your first prepayment:

Credit Card Debit Card

Please select one of the following options to make subsequent prepayments:

Credit Card Debit Card Automatic Bank Draft

Credit Card/Debit Card* MasterCard: Visa:

Card Account #:

Name on Card: _____ Card Expiration Date: ____/____/____

Card Billing Address (address where you receive your credit/debit card bills):

Street Address: _____

City: _____ State: _____ Zip: _____

3 to 7 digit code located in the signature box on the back of your credit/debit card:

Automatic Bank Draft Checking Account Savings Account

Name of Financial Institution: _____

Account Number: _____ Routing Number: _____

Name on Financial Institution Account: _____

*Credit or Debit Cards must have either a Mastercard or Visa Logo to be accepted for payment

Terms and Conditions

IMPORTANT: DO NOT CANCEL ANY COVERAGE YOU MAY NOW HAVE UNTIL YOU HAVE RECEIVED A POLICY FROM PRESBYTERIAN. Applicants accepted for coverage shall be provided a ten-day period from the effective date of coverage to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the member returns the contract to receive a refund of the premium paid, he or she must pay for such services.

Please be aware of a few major medical services that are **not** covered on this plan. The exclusions listed below are a summary of exclusions, and cannot modify or affect the Subscriber Agreement in any way, nor shall you accrue any rights because of any statement or omission from this summary. Covered benefits and services are subject to the provisions of the Subscriber Agreement. For a more complete list of exclusions please refer to the Summary of Benefits provided or you may request a Subscriber Agreement by contacting the Account Representative.

- ⇒ Benefits including, but not limited to, any condition which is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care, except as provided when a Maternity Rider is purchased.
- ⇒ Mental Health drugs and services, and alcohol and substance abuse services (except for detoxification only).
- ⇒ Artificial conception/infertility services including, but not limited to, diagnosis, treatment drugs and injections, artificial insemination, donor sperm, In-vitro, GIFT and ZIFT fertilization.
- ⇒ **A Pre-existing Condition limitation will apply to any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the (6) six-month period prior to the Member's enrollment under this plan unless prior proof of creditable coverage is provided.**

Applicants who have been diagnosed with or treated for certain conditions may have their Application denied. Please be advised this is not a detailed list of every condition that will result in denial, simply a summary of some of the conditions that will result in denial of an individual.

Cancer	Crohn's Disease
Stroke	AIDS/HIV+
Cardiac/Heart Disease	

Acceptance or denial of an Application is based on each individual. If one individual is denied the other members of the family may still be accepted.

Please do not send your estimated premium payment with your application. Any premium payments sent before acceptance by Presbyterian Insurance Company, Inc. (PIC) will not constitute approval or acceptance of health insurance coverage or bind coverage by PIC, including but not limited to, any deposit, negotiation or holding of such premiums or payments by PIC. I understand and agree that notwithstanding anything in the Application to the contrary; no coverage shall be considered accepted until approved by PIC.

I hereby consent, to the extent permitted by applicable law, to the use by or the release of my protected health information (PHI) by any person or entity including without limitation, practitioners, providers, and insurance companies to Presbyterian Insurance Company or its designees for any permitted purpose, including but not limited to, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment or healthcare operations activities of Presbyterian Insurance Company.

I understand that I am applying for individual health insurance coverage offered by Presbyterian Insurance Company, Inc.

I understand that Presbyterian Insurance Company, Inc. does not intend this health insurance coverage to be that of a small employer (group) health plan, and it is not represented as such. The state of New Mexico has enacted legislation governing Small Group health plans. This legislation impacts how insurers provide coverage to employees of small companies whose employees number from 2 to 50.

I understand that because this coverage is not that of a group health plan, I will not be entitled to any rights or protections governing such plans, including, for example, guaranteed renewability and portability.

I understand and acknowledge that I am fully responsible for the payment of all premiums associated with this individual coverage and that my employer is not paying, in full or in part, for any of the premiums or costs associated with any such coverage. My employer may only provide administrative support for the billing and/or submission of my individual Presbyterian Insurance Company, Inc. premium which is paid in full by me.

Further, I understand that in order for my employer to remit premium payments on my behalf, I authorize my employer access to (1) information regarding my (and any eligible dependent's) enrollment (as well as any changes thereto), and (2) information regarding the amount of my premium payment.

I understand that I am entitled to a copy of this Application if I request it.

I, the applicant (or legal guardian of minor Dependent), acknowledge that I have read and understand this Application in its entirety.

Authorization

By initialing below I hereby authorize Presbyterian Insurance Company or Presbyterian Health Plan and/or my broker on my behalf to accept coverage to enroll all applicants with an "approved" and/or "conditional approval" status. Approved means accepted to enroll in the plan originally requested. Conditional approval means the Underwriters have offered a different plan to the applicant, rather than declining coverage.

Initial

Upon acceptance and enrollment in a Presbyterian Individual Care Plan I, hereby authorize and request Presbyterian Insurance Company, Inc. to initiate withdrawal entries from the account(s) and the financial institution(s) indicated above for the monthly premium payments required by the Subscriber Agreement. These withdrawals are for premium payments for the approved and enrolled individuals listed in Section I of this Application only.

This authorization is to remain in effect until Presbyterian Insurance Company, Inc. and the financial institution(s) named above are notified in writing or through Presbyterian's designated website.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or 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 Insurance Company Inc. may terminate a member for any type of fraudulent activity.

I agree: By completing this Application I understand and agree that I have read this Application thoroughly and have verified the accuracy of all information contained herein, whether entered by me or by Presbyterian on my behalf, and warrant and represent my current and continuing authority to act on behalf of myself and all Dependents with respect to every provision of the Subscriber Agreement. All information on this form is correct and true. I understand this information is the basis on which coverage is issued under the plan. I understand that if approved, I will receive my Presbyterian Insurance Company Subscriber Agreement, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

_____	X	_____
Name of applicant (Please Print)	Signature of applicant (Required)	Today's Date
(or legal guardian if applicant is a minor)	(or legal guardian if applicant is a minor)	

I agree: By completing this Application I understand and agree that I have read this Application thoroughly and have verified the accuracy of all information contained herein, whether entered by me or by Presbyterian on my behalf, and warrant and represent my current and continuing authority to act on behalf of myself and all Dependents with respect to every provision of the Subscriber Agreement. All information on this form is correct and true. I understand this information is the basis on which coverage is issued under the plan. I understand that if approved, I will receive my Presbyterian Insurance Company Subscriber Agreement, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

_____	X	_____
Name of applicant's spouse	Signature of applicant's spouse	Today's Date
if applying (Please Print)	(Required) if applying	

For Agent/Broker Use Only – Must be completed for commissions to be paid.

Agency Name:
Presbyterian Agent/Broker ID#:

Broker Name:
Agent/Broker Phone #:

