

Individual Plan Member Add Dependent Form

Please complete the front and back of this form to avoid delay or possible denial of request.
 If you have questions, you may contact your broker, or our Individual Plan Call Center at
 1-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m.

RETURN OPTIONS

Please FAX this form to: (505) 923-5888	Please MAIL this form to: Presbyterian Insurance Company, Inc. P.O. Box 26267 Albuquerque, NM 87125-6267
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CHECK (✓) YOUR CURRENT PLAN

<input type="checkbox"/> PresMetro Plan	<input type="checkbox"/> PresSolo Plan	<input type="checkbox"/> Individual Care Plan	<input type="checkbox"/> Advantage Care Plan
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MEMBER INFORMATION

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

ADD OR MOVE A DEPENDENT

Check the correct box below to show the reason for the ADD or MOVE. You **must** complete and attach a Medical Questionnaire when adding a spouse or dependent. The Medical Questionnaire is *not* required when adding a newborn, newly-adopted child or a child for whom a Subscriber becomes a legal guardian **within 31 days** of birth, date of placement, or the court order granting guardianship.

<input type="checkbox"/> Newborn Add*/Date of Birth: _____ <input type="checkbox"/> Adoption* Date of Placement: _____ <input type="checkbox"/> Court Order*/Date of Order: _____	<input type="checkbox"/> Spouse/Dependent Add <input type="checkbox"/> Dependent move to a separate policy (same benefit plan) <input type="checkbox"/> Other, please describe: _____
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USE THIS SECTION TO ADD OR MOVE A DEPENDENT

Only your spouse and eligible unmarried dependent children under age 25 may be included in this section.

Social Security Number	Last Name	First Name	MI	DOB	Gender	Age	Relationship	AM =Add ME =Move	Effective Date

** Please refer to your Subscriber Agreement for information regarding qualifying events and required documentation.*

Presbyterian 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 effective date will be the date of birth, date of placement, or the court order granting guardianship.

You may download and print the Presbyterian Medical Questionnaire from our website at www.phs.org/healthplans. You may also request the Medical Questionnaire to be sent to you by calling us toll-free 1-866-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m. Coverage requests are subject to medical underwriting and are not guaranteed.

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS DOCUMENT

I agree: By signing this Application I warrant that I have read this Application and warrant my current and continuing authority to, and on behalf of, myself and all Dependents for whom I have legal authority to act on behalf of with respect to every provision of the Subscriber Agreement. All information on this Form is correct and true. I understand that is the basis on which coverage is issued under the Plan. I understand I will receive my applicable Presbyterian Health Plan (PHP) or Presbyterian Insurance Company Inc. (PIC) *Subscriber Agreement*, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

I hereby consent 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/PIC or its designees for any permitted purpose. Purposes 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 PHP/PIC. This consent shall not permit use or disclosure of PHI when authorization is required by law.

By initialing below, I hereby authorize Presbyterian Health Plan or Presbyterian Insurance Company Inc. (Presbyterian) and/or a 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**

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.

I understand that I am entitled to a copy of this signed Form upon request.

I acknowledge that I have read and understand this Application in its entirety.

Name of Applicant <i>(Please print)</i> (Or Legal Guardian if Applicant is a Minor)	X Signature of Applicant <i>(Required)</i> (Or Legal Guardian if Applicant is a Minor)	Today's Date
Name of Applicant's Spouse <i>If applying (Please print)</i>	X Signature of Applicant's Spouse <i>If applying (Required)</i>	Today's Date
Name of Applicant's Dependent <i>If applying and over 18 (Please print)</i>	X Signature of Applicant's Dependent <i>If applying and over 18 (Required)</i>	Today's Date
Name of Applicant's Dependent <i>If applying and over 18 (Please print)</i>	X Signature of Applicant's Dependent <i>If applying and over 18 (Required)</i>	Today's Date

PRESBYTERIAN ADMINISTRATIVE USE ONLY		
Department	Action	Submitted
Commercial Sales	<input type="checkbox"/> Auto approved / Effective Date: _____ <input type="checkbox"/> Underwriting Required	Date: _____ Dept: _____
Underwriting	<input type="checkbox"/> Approve: _____ / Accept Mail Date: _____ <input type="checkbox"/> Decline: _____ / Decline Mail Date: _____	Date: _____ Dept: _____
Commercial Sales	<input type="checkbox"/> Underwriting Request Approved / Effective Date: _____	Date: _____ Dept: _____