

Individual Plan Member Benefit Change 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

CHECK (✓) YOUR CURRENT PLAN

PresMetro Plan
 PresSolo Plan
 Individual Care Plan
 Advantage Care Plan

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:	

CHECK (✓) THE BOX BELOW FOR THE BENEFIT OPTION YOU WANT

If your request does not require medical underwriting and is received by the 10th of the month, your effective date will be the first of the following month. Presbyterian determines effective dates for requests requiring medical underwriting.

Note: If you do not select a Prescription Selection, the plan will default to the Standard Rx benefit or Option # 1 below.

1. PresMetro Plan * (all plans include standard dental and vision benefits):

Deductible Selection:
 \$500 Plan
 \$750 Plan
 \$1,000 Plan
 \$2,000 Plan
 \$5,000 Plan
 Prescription Selection:
 \$10/35/75 Standard Rx
 0/\$10 Generic Only Rx
 No Rx

2. PresSolo Plan * (all plans include standard dental and vision benefits):

Deductible Selection:
 \$500 Plan
 \$750 Plan
 \$1,000 Plan
 \$2,000 Plan
 \$5,000 Plan
 Prescription Selection:
 \$10/35/75 Standard Rx
 0/\$10 Generic Only Rx
 No Rx

3. Advantage Care Plan (Health Spending Account qualified High Deductible Health Plan)

Deductible Selection:
 \$1,200 Ind/\$2,400 Family
 \$2,500 Ind/\$5,000 Family
 \$5,000 Ind/\$10,000 Family
 Prescription Selection:
 20/20/30% Option #1
 No Rx Option #2

4. Individual Care Plan:

Deductible Selection:
 \$500 Plan
 \$750 Plan
 \$1,500 Plan
 \$1,000 Plan
 \$2,000 Plan
 \$2,500 Plan

If switching from the Individual Care Plan or Advantage Care Plan to PresMetro or PresSolo, would you like to elect the Dental Enhanced benefit for an additional \$19.50 per member per month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If currently enrolled in a Maternity Rider, would you like to continue your coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If currently enrolled in Delta Dental's Enhanced Dental option, would you like to continue coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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***Service Area Restrictions Apply**

If the plan you are requesting has (1) a lower plan deductible than your current plan and/or (2) includes a higher prescription benefit and/or plan benefit than your current plan, you must complete and attach a Medical Questionnaire to this Form. 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 contacting us at the toll free number listed on this form. Plan selection change requests are subject to medical underwriting and are not guaranteed. Covered benefits and services are subject to the provisions of the Subscriber Agreement. For a complete list of exclusions, please refer to the *Schedule of Benefits*. The *Schedule of Benefits* may be found at www.phs.org/healthplans, or you may contact our Individual Plan Call Center at 1-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m.

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: _____