

 **PRESBYTERIAN INSURANCE COMPANY INC.**  
**ShortTerm - PPO Plan**

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Period Deductible Options</b> Individual Family	\$500, \$1,000 and \$2,000 3 x Individual	\$1,000, \$2,000 and \$4,000 3 x Individual
<b>Benefit Period Out-of-Pocket Maximum</b> <i>(Includes co-insurance only)</i> Individual Family	\$2,000 3 x Individual	\$6,000 3 x Individual
<b>Maximum Lifetime Benefit</b>	Unlimited	Unlimited
<b>Physician Services</b> Non-Specialist and Specialist office visit	30%	50%
<b>Hospital<sup>1</sup></b> Inpatient/Outpatient	30%	50%
<b>Urgent Care</b>	30%	30%
<b>Emergency Care</b>	30%	30%
<b>Diagnostic Tests<sup>1</sup></b>	30%	50%
<b>Prescription Drugs</b>	Not Covered	Not Covered

<sup>1</sup>Benefit Certification may be required.

**If you would like to enroll in  
 Presbyterian Insurance Company's ShortTerm PPO plan,  
 please complete the Enrollment Application  
 on the following three pages and submit as instructed.**

**This plan does not cover pre-existing conditions. This plan is not considered Creditable Coverage, a Certificate of Creditable Coverage will not be provided when the benefit period is complete.**

**This summary of Covered Benefits and services is subject to the provisions of the Subscriber Agreement and cannot modify or affect the Subscriber Agreement in any way, nor shall you accrue any rights because of any statement in or omission from this summary. Refer to the Schedule of Benefits or Subscriber Agreement for more details on all Covered Benefits and Exclusions.**

## Individual Plan **ShortTerm** Enrollment Application

Temporary Individual Coverage

If you have questions, you may contact your broker or our Individual Plan Call Center 1-866-8MY-PRES,  
Monday through Friday from 8:00 a.m. to 5:00 p.m.

**SUBMIT BY FAX:**  
(505) 923-5888

**SUBMIT BY MAIL:**  
Presbyterian Insurance Company, Inc.  
P. O. Box 26267  
Albuquerque, NM 87125-6267

### SECTION 1: APPLICANT INFORMATION

#### Primary Applicant

First Name, MI, Last Name		Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	Social Security No.
Residential Address (No P.O. Boxes)	City	State	ZIP	
Mailing Address	City	State	ZIP	
Home Phone	Work / Message Phone	E-mail Address		

#### Other Applicants Legal Spouse / Dependent Children

Dependent children must be under age 26.

First Name, MI, Last Name	Spouse /child	Gender	Date of Birth	Social Security Number
		M <input type="checkbox"/> F <input type="checkbox"/>		
		M <input type="checkbox"/> F <input type="checkbox"/>		
		M <input type="checkbox"/> F <input type="checkbox"/>		
		M <input type="checkbox"/> F <input type="checkbox"/>		

### SECTION 2: EFFECTIVE DATE / BENEFIT PERIOD / DEDUCTIBLE SELECTION

Requested **Effective Date:** \_\_\_\_\_ (MM/DD/YY)

The benefit period you choose begins on either the requested effective date, or when your payment has been received by Presbyterian.

I (we) hereby apply for a

**Benefit period of**     30 days     60 days     90 days     120 days     150 days     180 days

**Deductible Selection**     \$500     \$1,000     \$2,000

Are you an existing Presbyterian Individual ShortTerm member applying for a 2<sup>nd</sup> benefit period?     Yes     No

Presbyterian ShortTerm members have 1 additional opportunity to re-apply for an additional benefit period after the initial benefit period has ended. Coverage may not exceed 360 days of continuous coverage. Additional benefit re-applications are subject to Medical Underwriting. Any condition which may have occurred under the prior policy is considered a Pre-existing Condition and not covered under any subsequent Presbyterian ShortTerm policy.

### SECTION 3: ELIGIBILITY

If the answer is "**No**" to the following question, **COVERAGE CANNOT BE ISSUED**

1. Are all Applicants New Mexico residents or live in New Mexico at least six (6) months each year?     Yes     No

## SECTION 4: MEDICAL QUESTIONNAIRE

1. Is any female to be covered now pregnant or is any male to be covered an expectant father?  Yes  No
2. In the past five years, have you or any family member to be covered ever received any medical or surgical consultation, advise or treatment including medication for any of the following: heart or circulatory system disorder including heart attack or stroke; diabetes; cancer or tumors; disorder of the blood; mental or nervous conditions or disorders; alcoholism or alcohol abuse; drug abuse, addiction or dependency?  Yes  No
3. Has any person applying for coverage been diagnosed as having acquired immune efficiency syndrome (AIDS) or AIDS-related complex, or has any person applying for coverage in the past five years tested positive for HIV virus (ELISA or Western Blot)?  Yes  No
4. Do you or any person named on this application plan on participating in motor vehicle or boat racing; mountain climbing; bungee jumping; hang gliding, skydiving or rodeo activities during this coverage?  Yes  No
5. Has any person applying for coverage been declined insurance due to health reasons within the past 18 months?  Yes  No

## SECTION 5: PAYMENT

### Authorization Agreement for Prepayments

(Presbyterian Insurance Company, Inc. – Individual Plans)

Presbyterian Insurance Company, Inc (PIC) is pre-paid health coverage, which means you pay your premium payment for coverage prior to the month of coverage. Please select your premium payment option below by putting a checkmark in the appropriate boxes, and then complete the corresponding financial information. If you are accepted, you will receive an Acceptance letter with 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 your premium payments by contacting the Presbyterian Customer Service Center by e-mail at info@phs.org. You may also call (505) 923-6980 or toll-free at 1-800-923-6980, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407. The effective date of the change will be dependent on the time of month the request is made, and the type of payment method requested.

**Please do not send your estimated premium payment with your Application.** Any premium payments sent before acceptance by 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 not withstanding anything in the Application to the contrary; no coverage shall be considered accepted until approved by PIC.

Select one of the following payment options

**Payment Option #1 Single Payment** Credit or Debit Card only

Available for benefit periods of 30 days -180 days.

**Payment Option #2 Pre-paid Monthly Draft** 1<sup>st</sup> payment must be made by Credit or Debit Card only

Available for benefit periods of 60 days -180 days. \$10.00 fee will be added to your monthly premium each month.

Subsequent pre-payments by Credit/Debit Card **OR**  Subsequent pre-payments by Automatic Bank Draft

### Credit Card / Debit Card

MasterCard  VISA  Discover Card

Card Account # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name on Card \_\_\_\_\_ Card Expiration Date \_\_\_\_/\_\_\_\_

[Billing Address (address where you receive your Credit/Debit card statements).]

[Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_]

### Automatic Bank Draft

Checking Account  Savings Account

Name of Financial Institution: \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing Number \_\_\_\_\_

Name of Account Holder: \_\_\_\_\_

**SECTION 6: TERMS AND CONDITIONS**

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 medical 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.

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](http://www.phs.org/healthplans) or you may contact our Individual Plan Call Center at 1-866-8MY-PRES (1-866-869-7737), Monday through Friday from 8:00 a.m. to 5:00 p.m.

**SECTION 7: REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS**

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, Inc.

I understand that I am applying for short term individual health insurance coverage offered by Presbyterian Insurance Company, Inc. This plan does not cover Pre-existing Conditions. Benefits are not payable for services related to Pre-existing Conditions. This plan is not considered Creditable Coverage and therefore the Pre-existing Condition limitation cannot be offset by Coverage the Member had under another plan.

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 and acknowledge I am fully responsible for the payment of all premiums associated with this individual coverage and 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.

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

I hereby authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) for the purpose of evaluating my application for insurance.

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. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Presbyterian.

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 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 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, Inc. Subscriber Agreement, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

<b>Name of Applicant or Legal Guardian</b> <i>(please print)</i>	<b>X</b> <b>Signature of Applicant or Legal Guardian</b> <i>(required)</i>	<b>Today's Date</b>
<b>Name of Applicant's Spouse</b> <i>If applying (please print)</i>	<b>X</b> <b>Signature of Applicant's Spouse</b> <i>If applying (required)</i>	<b>Today's Date</b>
<b>Name of Applicant's Dependent</b> <i>If applying and over 18 (please print)</i>	<b>X</b> <b>Signature of Applicant's Dependent</b> <i>If applying and over 18 (required)</i>	<b>Today's Date</b>

**PRODUCER For Producer Use Only – must be completed for commissions to be paid.**

Producer Name: _____	Agency Name: _____
Producer Phone Number: _____	Producer Presbyterian ID Number: _____