

Employer Information		
Employer:	Sub-group / Department:	Group Number:

Section A: Type of Action			
<input type="checkbox"/> New Enrollment or Qualifying Event:		<input type="checkbox"/> Waive Coverage (complete Section A, sign and date)	<input type="checkbox"/> Terminate Coverage
<input type="checkbox"/> Open/New Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Other Coverage	Date:
<input type="checkbox"/> Qualifying Event	<input type="checkbox"/> Newborn	<input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	Reason:
<b>Date of Event:</b>	<input type="checkbox"/> Marriage	<input type="checkbox"/> Other Employer: _____	
	<input type="checkbox"/> Court Order	<input type="checkbox"/> Selecting no coverage	
Presbyterian plan selected if more than one plan is offered by employer: _____ <input type="checkbox"/> Single <input type="checkbox"/> Two-party <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> Family Dental Coverage Selected: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, all family members will be enrolled in the plan selected by employer)			

Section B: Employee Information					
Employee Last Name:	Employee First Name & MI:	Date of Birth:	Phone #'s:		Social Security #:
			Wk.: (   )		
			Hm./Cell: (   )		
Mailing Address:		City:	State:	Zip:	Email Address:
Employment Status:	Date of Hire:	Occupation:	Gender:	Ethnicity (optional):	Other Language/ Disability Needs:
<input type="checkbox"/> Fulltime <input type="checkbox"/> Part-time Hours per wk: _____					

Section C: Dependent Information								
Dep. Type:	Last Name:	First Name & MI:	Social Security #:	Gender:	Date of Birth:	Eff. Date:	Primary Care:	Court order?
Spouse								
Child								
Child								
Child								
Child								

Section D: Other Medical Benefits For Coordination (if applicable)			
Family Member Name(s):	<input type="checkbox"/> Private Insurance: _____	<input type="checkbox"/> Medicare #: _____	<input type="checkbox"/> Not applicable

Section E: Consent / Signatures	
You must read the reverse side of this application. By signing this application you agree you have read all pages and agree that all information is correct and you have authority to act on behalf of and fully bind all of the dependents with respect to every provision of the Group Subscriber Agreement.	
Employee Signature:	Date Signed:

## Please Read Carefully

### Payroll Deduction

I HEREBY AUTHORIZE my employer to deduct from my pay check any required contribution for group benefits for which I am eligible.

### Release of Protected Health Information

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 Health Plan, Inc. or Presbyterian Insurance Company, Inc. (Presbyterian) 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. This consent shall not permit use of PHI when an authorization is required by law. For full description of Presbyterian's privacy practices as related to oral, written and electronic data and communication, please visit our website at [www.phs.org/Pages/privacy-security.aspx](http://www.phs.org/Pages/privacy-security.aspx) or call customer service at (505) 923-5678.

### Group Subscriber Agreement/Summary Plan Description/Certificate of Insurance

I understand I can access my Presbyterian Group Subscriber Agreement, Summary Plan Description or Certificate of Insurance, which contains the covered benefits, utilization management services, limitations, and exclusions applicable to my healthcare plan at [www.phs.org/formsanddocuments](http://www.phs.org/formsanddocuments). I understand that a Presbyterian representative or my personnel office will further explain the coverage for which I am eligible upon my request. I understand that my healthcare coverage is subject to the eligibility dates specified by my employer and Presbyterian. I will be financially responsible for any treatment received outside of the dates. I understand that I shall abide by the provisions of the coverage in the Group Subscriber Agreement or Summary Plan Description or Certificate of Insurance under which I am enrolled. I understand that it is my responsibility to report to my employer any changes in the eligibility of my dependents within 31 days or as specified in the Group Letter of Agreement. Exclusions, limitations, rights and responsibilities can be reviewed in Group Subscriber Agreement. Please call 1-866-869-7737 to request a copy of this agreement.

### Waiver of Health Coverage

I understand that by declining Presbyterian coverage for myself (and my family, if applicable) through my employer that:

1. I may not elect or enroll in this coverage until the next open enrollment period unless I experience an involuntary loss of coverage or acquire a new dependent.
2. I may in the future under certain circumstances be able to enroll myself (and my family, if applicable) in the plan provided that I request enrollment within 31 days after the other coverage ends.
3. In addition, if I acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

### Enrollment Instructions

Please complete all of the applicable sections of the Employee Action Form (enrollment form). Sign and date the form and return it to your employer's benefits administrator. The benefits administrator will write in your effective date. The effective date is the date your coverage under Presbyterian begins. Any services provided prior to this date will not be covered by Presbyterian.

### Pediatric Dental

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 insurance carrier, agent or the New Mexico Health Insurance Exchange (<http://www.nmhix.com>) if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

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.

## **Notice of Nondiscrimination and Accessibility**

*Discrimination is Against the Law*

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at 505- 923-5420, 1-855-592-7737, TTY: 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer and Civil Rights Coordinator is available to help you.

Presbyterian Privacy Officer and Civil Rights Coordinator

P.O. Box 27489

Albuquerque, NM 87125

Phone: 1-866-977-3021, TTY: 711

Fax: 505-923-5124

Email: [info@phs.org](mailto:info@phs.org)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh éí ná hóló, koji' hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	لننت تتحدث انكسر لال لغة، فان خدمات الامس اعدة لال غوية تتوافر لك بل ام جان. اتصل برقم 505-923-5420, (TTY: 711), 1-855-592-7737 رقم هاتف لاصم ول ابككم. مل حوطة: اذا
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오.
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420, 1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان انگلیسی صحبت می کنید، سرویس های دستیار زبان به صورت رایگان در اختیاران قرار می گیرند. با شماره 505-923-5420, 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).