



Health Plan
 PO Box 27489
 Albuquerque, New Mexico 87125-7489
 (505) 923-5700 / Toll-Free 1-800-356-2219

Insurance Company, Inc
 PO Box 26267
 Albuquerque, New Mexico 87125-6267
 (505) 923-6980 / Toll-Free 1-800-923-6980

EMPLOYEE ACTION FORM

Type of Action

- New Enrollment Marriage Date _____
 Termination Date _____ Birth Date _____
 Out of Area Court Order Other Date _____

EMPLOYER GROUP NAME _____

 EMPLOYER GROUP # _____

Presbyterian serves to improve the health of individuals, families and communities.

WAIVER: I hereby waive Presbyterian Medical Coverage. (Complete Section A and sign and date form.)
 REASON FOR WAIVER: Not Covered Covered by a Commercial Individual Plan --Name of Insurance Company _____
 Covered by another Employer Group Plan--Name of Insurance Company _____ Name of Employer _____
 Other Coverage -- Explain: _____

SECTION A. EMPLOYEE INFORMATION

EMPLOYEE LAST NAME		FIRST NAME		M.I.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS		APT./STE #	CITY	COUNTY	STATE	ZIP CODE
MARITAL STATUS	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> MARRIAGE DATE _____	GENDER/SEX M <input type="checkbox"/> F <input type="checkbox"/>	HOME PHONE () ()	WORK PHONE () ()	PREFERRED E-MAIL ADDRESS	

SECTION B. COVERAGE INFORMATION

Not all employers offer a choice of health plans. Your selection will be limited to the benefit plans made available to you by your employer. Any/All benefit discrepancies will default to the benefit plan offering selected by your employer. Please review the information in your enrollment materials or check with your benefits coordinator if you uncertain about the types of benefit plans available to you. Your coverage election will be the health benefit made by your employer.
 IF YOUR EMPLOYER OFFERS TWO OR MORE PRESBYTERIAN BENEFIT PLANS YOU MUST SELECT ONE:
 HMO POS PPO INDEMNITY
 COVERAGE APPLIED FOR SINGLE TWO-PARTY FAMILY EMPLOYEE + CHILD(REN)
 IF YOUR EMPLOYER OFFERS THE "MY CARE PLAN" YOU MUST SELECT ONE:
 ACTIVE FAMILY INDEPENDENT

SECTION C. EMPLOYEE / DEPENDENT INFORMATION

COMPLETE FOR HMO OR POS PLANS ONLY

	Last Name	First Name	M.I.	SOCIAL SECURITY NUMBER FOR ALL LISTED MEMBERS	DATE OF BIRTH	GENDER/SEX	PRIMARY CARE PHYSICIAN	ARE YOU ESTABLISHED WITH THIS PHYSICIAN?
Employee					/ /			<input type="checkbox"/> Y <input type="checkbox"/> N
Legal Spouse					/ /			<input type="checkbox"/> Y <input type="checkbox"/> N
Child					/ /			<input type="checkbox"/> Y <input type="checkbox"/> N
Child					/ /			<input type="checkbox"/> Y <input type="checkbox"/> N
Child					/ /			<input type="checkbox"/> Y <input type="checkbox"/> N

OUT OF AREA (OOA) COURT ORDERED DEPENDENT INFORMATION: DEPENDENT LAST NAME _____ FIRST NAME _____ SOCIAL SECURITY NO. _____
 MAILING ADDRESS OF OOA DEPENDENT: ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
 DO YOU OR ANY DEPENDENTS REQUIRE ANY ASSISTANCE DUE TO A DISABILITY? IF YES, PLEASE DESCRIBE. _____ DO YOU OR ANY DEPENDENTS SPEAK A LANGUAGE OTHER THAN ENGLISH? IF YES, PLEASE LIST. _____ IS THIS YOUR PRIMARY LANGUAGE? YES NO

SECTION D. COORDINATION OF BENEFITS

WILL YOU OR ANY OTHER FAMILY MEMBER LISTED ABOVE CONTINUE TO BE COVERED BY ANY OTHER HEALTH INSURANCE OR HMO? YES NO
 IF YES, LIST INSURANCE COMPANY _____ IF YES, LIST NAME(S) _____ DO YOU OR ANY FAMILY MEMBER LISTED ABOVE HAVE MEDICARE? YES NO
 IF YES, NAME OF MEMBER, MEDICARE NUMBER, EFFECTIVE DATE, PART A PART B _____

SECTION E. EMPLOYER INFORMATION

OCCUPATION _____ DATE OF HIRE OR DATE REINSTATED ____/____/____ HOURS WORKED PER WEEK _____ EFFECTIVE DATE OF COVERAGE _____

IMPORTANT: YOU MUST READ THE REVERSE SIDE OF THIS APPLICATION. By signing this application, I warrant that I have read both sides of this application and warrant my current and continuing authority to act on behalf of and fully bind all of the above Dependents with respect to every provision of the Group Agreement.

Employee Signature _____ Date _____ Spouse's Signature (If enrolling) _____ Date _____

PLEASE READ CAREFULLY

Payroll Deduction

I hereby authorize my employer to deduct from my paycheck 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 or 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 Health Plan or Presbyterian Insurance Company. This consent shall not permit use of PHI when an authorization is required by law.

Group Subscriber Agreement / Summary Plan Description / Certificate of Insurance

I understand I will receive my Presbyterian Health Plan or Presbyterian Insurance Company Group Subscriber Agreement or Summary Plan Description or Certificate of Insurance which contains the benefits, limitations and exclusions applicable to my health care plan. I understand that the coverage for which I am eligible will be further explained upon request by a Presbyterian Representative or my personnel office. I understand that my health care coverage is subject to the eligibility dates specified by my employer and Presbyterian Health Plan or Presbyterian Insurance Company and I will be financially responsible for any treatment received outside of these 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.

Waiver of Health Coverage

I understand that by declining Presbyterian Health Plan or Presbyterian Insurance Company, Inc. 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 (any 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 the applicable sections of the employee action form (enrollment form). Sign and date the form and return it to your employer group's Benefit Administrator. The Benefit Administrator will write in your effective date. The effective date is the date your coverage under Presbyterian Health Plan or Presbyterian Insurance Company begins. Any services provided prior to this date will not be covered by Presbyterian Health Plan or Presbyterian Insurance Company.

Make a copy of the employee action form (enrollment form) for your records.