Employee Action Form

Scan and email this completed form to enrollmentdept@phs.org or fax to the Presbyterian Sales Department at (505) 923-8225.

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

EMPLOYER INFORMATION

Employer:	Sub-group/Department:	Group Number:
Architectural Research Consultants, Incorporated		A0002656

SECTION A: TYPE OF ACTION

☐ New Enrollment or Qualifying Event:	☐ Waive Coverage (complete Section A, sign and date)	☐ Terminate Coverage
☐ Open/New Enrollment ☐ Qualifying Event: ☐ New Hire ☐ Newborn ☐ Marriage ☐ Court Order Date of Event:_____ **attach documented proof of event.*	☐ Other Coverage ☐ Individual ☐ Medicare ☐ Medicaid ☐ Other Employer: _____ ☐ Selecting no coverage	Date: Reason:
Benefit Plan Selected:	Coverage selected: ☐ Single ☐ Two-party ☐ EE + Child(ren) ☐ Family	
Dental Coverage Selected: ☐ Yes ☐ 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 Numbers:	Social Security Number:
			Work: ( ) Home/Cell: ( )	

Mailing Address:	City:	State:	Zip:	Email Address:

Employment Status:	Date of Hire:	Gender:	Race (optional)	Ethnicity (optional):	Other Language/Disability Needs:
☐ Full Time ☐ Part Time # of hours:_____			☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Two or more races	☐ Hispanic/Latino ☐ Non-Hispanic/Latino	Primary Care:

SECTION C: DEPENDENT INFORMATION

Dependent Type:	Last Name:	First Name and 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):	☐ Private Insurance: _____	☐ Medicare #:_____	☐ Not applicable

SECTION E: CONSENT / SIGNATURES

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 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. 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 bythe 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. Scan and email this completed form to enrollmentdept@phs.org or fax to the Presbyterian Sales Department at (505) 923-8225.

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.

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services - https://www.phs.org/Pages/nondiscrimination.aspx