

Individual Plan Enrollment Application

If you have questions, you may contact your broker or our Individual Plan Sales Team at 1-866-869-7737, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users, please call 1-877-298-7407. You can also e-mail us at iplan@phs.org.

SUBMIT BY MAIL: Presbyterian Insurance Company, Inc. P. O. Box 26267 Albuquerque, NM 87125-6267	SUBMIT BY FAX: (505) 923-5888
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APPLICATION INSTRUCTIONS

1. This Application must be completed with black or blue ink only. Illegible Applications or Applications completed in pencil or erasable ink will be returned. Changes or corrections to this Application must be made by striking out the change/mistake with a line and initialing the change. Do not use correction tape or fluid.
2. Questions must be answered with complete details given for any "yes" answers. You are responsible for the accuracy and completeness of all information entered on this form. Full disclosure is essential in processing your application; incomplete applications may result in delays and/or declination. If more space is needed, attach a separate page(s) and list section(s) and question numbers, then sign and date each page.
3. All legal-age Applicants must personally sign and date this Application. If your spouse or any dependent(s) age 18 or over are also applying for coverage, they must personally sign and date this Application on the appropriate signature line.

Submission Deadlines - Coverage will be effective on either the first (1) or the fifteenth (15) day of the month, if coverage is approved. The completed application must be received by the 1st of the month for a 15th of the month effective date or by the 15th of the month for a 1st of the next month effective date.

SECTION 1: APPLICANT INFORMATION

Primary Applicant

*Tobacco use in last 24 months

If applying for *Classic for Kids* a child-only plan, list the child's information as the Primary Applicant.

First Name, MI, Last Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mo/day/yyyy)	Social Security Number	Height (ft, in.) ___' ___"	Weight (lbs.)	Tobacco use* Y <input type="checkbox"/> N <input type="checkbox"/>
Residential Address (No P.O. Boxes)		City	State	County	ZIP Code	
Home Phone	Daytime Phone	E-mail Address		Spouse's Daytime Phone (if applying)		
Mailing Address		City	State	County	ZIP Code	

Other Applicants

*Tobacco use in last 24 months

Dependent children must be under age 26.

Name First Name, MI, Last Name	Relation (Spouse /child)	Gender	DOB (m/d/yr)	SSN	Height (ft., in.)	Weight (lbs.)	Tobacco use*
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>

If any one Applicant is denied coverage, do you wish to cover the remaining Applicants? Y N

SECTION 2: EFFECTIVE DATE SELECTION

Important: *Do not* cancel any coverage you may have now until you have received confirmation of acceptance from Presbyterian Insurance Company, Inc.

- First of the month ONLY (next available) Fifteenth of the month ONLY (next available) Next available (first OR 15th)
 Other _____ 1st or 15th _____ (within 60 days of your signature date for this Application)
Mo day year

SECTION 3: COVERAGE OPTIONS

SELECT PLANS

Available in New Mexico, excluding Eddy and Lea Counties.

All Select Plans include Standard Dental and Vision Benefits. Comprehensive Dental benefits available for an additional premium. Choose a deductible and a prescription selection below.* This plan is not available for child-only applications.

- Deductible Selection \$1,000 Plan \$2,000 Plan \$5,000 Plan
Prescription Selection* Option #1-\$10/\$35/\$75 Standard Rx Option#2-\$0/\$10 Generic Only Rx Option#3-No Rx
 Add the **Select Comprehensive Dental Plan** (additional monthly premium of **\$21.00** per member per month)

CLASSIC PLANS

Available in New Mexico, excluding Eddy and Lea Counties. Comprehensive Dental benefits available for an additional premium. Choose a deductible and a prescription selection below.* This plan is not available for child-only applications.

- Deductible Selection \$1,000 Plan \$2,000 Plan \$5,000 Plan
Prescription Selection* Option #1-\$10/\$35/\$75 Standard Rx Option#2-\$0/\$10 Generic Only Rx Option#3-No Rx
 Add the **Standard and Comprehensive Dental Plan** (additional monthly premium of **\$28.55** per member per month)

SAVVY 100 PLANS

Available in New Mexico, excluding Eddy and Lea Counties. Health Savings Account (HSA) qualified High Deductible Health Plan. Comprehensive Dental benefits and the Health Savings Account option are available for an additional premium. Choose a deductible and a prescription selection below.* This plan is not available for child-only applications.

- Deductible Selection \$2,000 (Individual¹) \$4,000 (Family²) \$4,000 (Individual¹) \$8,000 (Family²)

¹Individual Coverage: One member on a contract.

²Family Coverage: Two or more members on a contract. The entire family deductible must be met before the plan pays for any services except Preventive Care.

- Prescription Selection* Option #1 – \$0 Copay after deductible is met Option #2 - No Rx coverage
 Add the **Standard and Comprehensive Dental Plan** (additional monthly premium of **\$28.55** per member per month)
 Add the **Health Equity Health Savings Account Option** (additional monthly premium of **\$1.95** per month)

CLASSIC FOR KIDS

Available in New Mexico, excluding Eddy and Lea Counties. A child-only guaranteed issue plan for children under age 19. Choose a deductible and a prescription selection below.* Comprehensive Dental benefits available for an additional premium.

- Deductible Selection \$1,000 Plan \$2,000 Plan \$5,000 Plan
Prescription Selection* Option #1-\$10/\$35/\$75 Standard Rx Option#2-\$0/\$10 Generic Only Rx Option#3-No Rx
 Add the **Standard and Comprehensive Dental Plan** (additional monthly premium of **\$28.55** per member per month)

Complete the section below if applying for the child-only Classic for Kids plan and your child is under age 19.

The child's Parent, Legal Guardian or Trustee must complete this Application. Failure to provide supporting documentation may result in a denial or retroactive termination of coverage.

Parent / Legal Guardian / Trustee – First Name, Middle Initial, Last Name	I am the child's Parent <input type="checkbox"/> Trustee <input type="checkbox"/> Legal Guardian <input type="checkbox"/>	Home Phone	Daytime Phone	
Mailing Address	City	State	County	ZIP Code

* The prescription benefit will default to "Standard RX" or "Option #1" if a selection is not made.

SECTION 4: ELIGIBILITY

1. Do all Applicants live in New Mexico at least six (6) months each year? Yes No
2. Are any Applicants a new parent of an infant less than 31 days old? Yes No
 If "yes," Applicant name(s) _____

SECTION 5: GENERAL INFORMATION

1. Where did you hear about Presbyterian's Individual Plans?
 Broker Newspaper TV Radio Direct Mail My Doctor
 Other _____
2. Is any Applicant a current Presbyterian Health Plan or Presbyterian Insurance Company member
 If "yes," Applicant name _____ member number _____ Yes No
3. Has any Applicant previously applied for coverage with Presbyterian in the last six (6) months?
 If "yes," Applicant name _____ Yes No
4. Has any Applicant applying for coverage had claims in excess of \$5,000 during the past twelve (12) months?
 If "yes," Applicant name _____ Yes No
 Condition/treatment _____
5. Has any person applying for coverage been denied health insurance coverage in the past (6) six months?
 If "yes," Applicant name _____ Insurance Company _____ Yes No
 Reason for decline _____

SECTION 6: MEDICAL QUESTIONNAIRE

- All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.
- Within the last **10 years**, please mark "Yes" or "No" if any person applying for coverage has been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended treatment for the following.

If you answer "Yes" to ANY question below, underline or circle the condition, if applicable, and provide details in Section 7.

1. Any migraines, headaches, epilepsy, seizures, head injury, concussion, paralysis, neurological disorder, multiple sclerosis, ADD/ADHD, anxiety, depression, schizophrenia, obsessive compulsive disorder (OCD), bipolar disorder, mental retardation, autism, or any other nervous system or behavioral, mental or psychological disorder or condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Any chest pain, palpitations, heart murmur, mitral valve prolapse, arrhythmia or irregular heartbeat, heart attack, stroke or TIA, or any other heart or circulatory disorder or condition, or hypertension / high blood pressure (HBP)? If "yes" to HBP, provide 3 readings and their dates within the last year. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Elevated cholesterol, triglycerides or other lipids (including if controlled by diet or exercise)? If "yes," provide the date and results of most recent testing: Date: _____ Total Chol: _____ HDL: _____ Triglycerides: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Any blood disorders, hemophilia, blood clot, anemia, varicose or spider veins, varicosities, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV positive or any other immune system or blood disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Any asthma, allergies, sinusitis, bronchitis, pneumonia, tuberculosis, apnea, chronic obstructive pulmonary disease (COPD), emphysema, breathing difficulty, or any other lung or respiratory disease, disorder or condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>6. Any colitis, ulcerative colitis, irritable bowel syndrome (IBS), Crohn's disease, liver, stomach or pancreas disorders, hepatitis, ulcer, hernia, GERD, diverticulitis, esophagitis, Barrett's esophagus, chronic diarrhea, rectal, colon or other digestive disorder or condition? If "yes" to hernia, indicate type: _____ If "yes" to hepatitis, indicate which type: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>7. Any cancer, tumor, growth, cyst, polyp, enlarged lymph node(s), or leukemia? If "yes," indicate diagnosis & location _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>8. Any acne, keratosis, psoriasis, basal cell carcinoma, and malignant melanoma, lesions of the skin or mouth, hemangioma, or any other skin disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>9. Any kidney stones, urinary reflux, urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>10. Any breast cyst or nodule, gynecomastia, fibrocystic breast disease, breast implants, or any other disease or disorder of the breast?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>11. Any back, spine, neck or disc disorder, pinched nerve, whiplash, back pain, strain or curvature? Any arthritis, gout, bunion, bursitis, carpal tunnel syndrome, fracture, TMJ, or disorder or pain in any joints, knee, shoulder, jaw or joint replacement, or chiropractic adjustments, physical therapy or manipulations? If "yes" to arthritis, indicate type: _____ Location: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>12. Any hypothyroidism, hyperthyroidism, Graves' disease, goiter, nodule or any other thyroid disorder, diabetes, elevated blood sugar, glucose intolerance, insulin resistance or any other metabolic, endocrine, pituitary or adrenal disorder, lupus, chronic fatigue syndrome, connective tissue or autoimmune disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>13. Any cataracts, glaucoma, hearing loss, deviated nasal septum, or any other eye, ear, nose, speech or throat disorder?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>14. For all MALE applicants (adults and children) Prostate disorder, elevated prostate specific antigen (PSA), sexually transmitted disease, genital warts, herpes, erectile dysfunction, or any other disease or disorder of the genital or reproductive system?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>15. For all FEMALE applicants (adults and children) Fibroid or uterine tumor, ovarian cyst, endometriosis, infertility, cystocele, rectocele, sexually transmitted disease, cervical dysplasia, genital warts, herpes, HPV, or any other disease or disorder of the genital or reproductive system? If "yes" to cervical dysplasia indicate type and length of time since normal Pap test: Type: _____ Length of time: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>16. During the last 12 months, has any applicant been prescribed or advised to take medication (other than for the common cold or flu or contraceptives to prevent pregnancy) other than indicated elsewhere on this application? If unsure of the reason for any ongoing medication use, please verify with your physician.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>17. Applies to both MALE and FEMALE applicants (including dependents): Is <u>any</u> applicant currently pregnant or now an expectant parent? If "yes," coverage cannot be offered. Exception: Applicants under age 19 applying for Classic for Kids, (child-only guaranteed issue plan for children under age 19).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>18. Does any applicant have or ever had an implant (e.g., breast, chin, or penile implant, etc.), internal fixation (e.g., pins, plates, rods, screws or spinal cage), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device other than indicated elsewhere on this application? If "yes" to breast implants: Have there been any complications or has either of the breast implants(s) been replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cosmetic Reasons <input type="checkbox"/> Disease/Illness/Injury/Congenital Anomaly</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>19. Does any applicant drink beer or alcohol? If "yes," please complete the following: Note: 1 drink is equivalent to one 12-oz beer, one 5-oz glass of wine or 1.5- oz of hard liquor Applicant's name: _____ Average number of drinks per week: _____ Applicant's name: _____ Average number of drinks per week: _____ Applicant's name: _____ Average number of drinks per week: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered "YES" to any questions in Section 6, please give complete details in Section 7.

20. Has any Applicant been diagnosed with, advised to seek treatment for, been counseled, or treated for alcohol, chemical or drug use, abuse or dependency? If "yes", name of drug or chemical: _____ (and provide details/dates in section 7)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Has any applicant been advised to have or discussed any treatments, diagnostic testing, counseling, therapy, hospitalization, surgery or medications that have not yet been performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Has any applicant ever been seen tested, hospitalized, or had surgery for a bypass, angioplasty, stent, aneurysm, valve replacement, cancer, stroke, gastric or weight loss surgery, congenital abnormality, or organ transplant other than indicated elsewhere on this application?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

23. Complete the following for **all** Applicants applying for coverage:

Applicant's Name	Date of last routine physical	Exam Results	
		*Abnormal results include any recommendations for additional testing, medication or follow-up. If abnormal, give details in Section 7.	
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal *
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal *
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal *
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal *
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal *

SECTION 7: DETAILS OF HEALTH HISTORY

If you answered "yes" to ANY question in Section 6 – Health History/Medical Questions, please provide further information in the spaces below. Be sure to use the example entry as your guide. If more space is needed, attach a separate page, which must be signed and dated.

Q #	Applicant affected	Condition, Injury, Symptom, or Diagnosis			Types of treatment including surgery or procedure(s)	Medications prescribed. Are you currently taking? Indicate Yes or No	Treating Physician's name
		Description (specify left or right if applicable)	Date started	Date of recovery (If applicable)			
3	Joe Smith	High Blood Pressure	6/95	No, Ongoing	Stress Test	40 MG Atenolol, once daily. Yes, still taking	Dr. Smith

In order to process your application, the Underwriting Department may need to contact you to request additional information. Please ensure that you have completed the daytime phone number in Section 1.

SECTION 8: BILLING INFORMATION

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 first premium payment and your subsequent premium payment choices by putting a checkmark in the appropriate boxes below, and then complete the corresponding financial information for both selections. When your first premium payment is drafted or charged, and clears your financial institution, your coverage will become effective either on the first (1) or the fifteenth (15) of the month after acceptance, per your specified Effective Date Selection. 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 subsequent 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 notwithstanding anything in the Application to the contrary; no coverage shall be considered accepted until approved by PIC.

PAYMENT INFORMATION IS REQUIRED FOR APPLICATION PROCESSING

Payments: Please select one of the following options to make prepayments

- Credit Card / Debit Card Automatic Bank Draft

Credit Card / Debit Card

- MasterCard VISA Discover Card

Card Account # _____ - _____ - _____ - _____

Name on Card _____ Card Expiration Date ____/____

Card 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 9: 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. Please be aware of a few major medical services that are not covered on this plan. The exclusions listed below are a summary of exclusions, and cannot modify or affect the *Subscriber Agreement* in any way, nor shall you accrue any rights because of any statement or omission from this summary. Covered benefits and services are subject to the provisions of the *Subscriber Agreement*. For a more 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 Sales Team at 1-866-8MY-PRES (1-866-869-7737), Monday through Friday from 8:00 a.m. to 5:00 p.m.

- Benefits including, but not limited to, any condition that is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care.
- Mental Health drugs and services or alcohol and substance abuse services (except for detoxification only).
- Artificial conception/infertility services including, but not limited to; diagnosis, treatment drugs and injections, artificial insemination, donor sperm, In-vitro, GIFT and ZIFT fertilization.
- A Pre-existing Condition Limitation will apply to any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the (6) six-month period prior to the Member's enrollment under this plan unless prior proof of Creditable Coverage is provided. A Pre-existing Condition Limitation does not apply to dependents under age 19.

Proof of coverage must be provided for Pre-existing Condition credit. A Certificate of Creditable Coverage from prior carrier/insurance company is an acceptable form of proof. Failure to provide proof of prior coverage may subject you or your family members to the full Pre-existing Condition Limitation with no credit for prior coverage. You are entitled to a Certificate of Creditable Coverage from your prior carrier/insurance company. Pre-existing Conditions are diseases or conditions for which medical advice, diagnosis, care or treatment was recommended or received within the (6) six-month period before the individual's effective date on this plan.

SECTION 10: 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, Inc. 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.

I understand that I am applying for individual health insurance coverage offered by Presbyterian Insurance Company.

I understand that Presbyterian Insurance Company 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 that because this coverage is not that of a group health plan, I will not be entitled to any rights or protections governing such plans, including, for example, guaranteed renewability and portability.

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.

Further, I understand that in order for my employer to remit premium payments on my behalf, I authorize my employer access to (1) information regarding my (and any eligible dependent's) enrollment (as well as any changes thereto), and (2) information regarding the amount of my premium payment.

I understand that I am entitled to a copy of this Application if I request it.

I understand I may be offered coverage at a rate that is different from the Standard Rate.

I, the Applicant (or Legal Guardian of Minor Dependent), acknowledge that I have read and understand this Application in its entirety.

SECTION 10: REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS (cont.)

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 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 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. 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.

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

*Application will expire within 60 days from the date of your signature.

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

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