Physicians Health Plan

Clear Form

Individual Off-Marketplace Health Plan Change Form

Requirements and Rules for Adding a Dependent or Updating Your Enrollment.

- ✓ You must live in one of the following counties to change your individual plan:
  - Clinton
  - Eaton
  - Ingham
  - Ionia
  - Isabella
  - Shiawassee
  - Montcalm
  - Livingston - zip codes 48169, 48114, 48116
  - Washtenaw
  - Saginaw
  - Bay
  - Tuscola
  - Huron
  - Sanilac
- ✓ You must be a citizen of the United States (U.S.) or a permanent resident. Proof of citizenship or permanent residency is required.
- ✓ Applicants 20 years and under applying for a Child Only Policy can only have single coverage.
- ✓ Coverage will be provided under an individual contract. Physicians Health Plan (PHP) does not issue individual coverage through any arrangement with an employer.
- ✓ You/Your dependent are not eligible for this policy if you or your dependent is either enrolled or entitled to Medicare.
- ✓ The SBC for each plan can be found on PHP's website at ChoosePHPMI.com or available free of charge when requested by calling Customer Service. Before enrolling in one of the plans, check the provider directory to make sure your providers are in the PHP network, review the enclosed rate sheet, and read the plan information.
- ✓ After submitting this change form, you will receive a confirmation letter with your monthly premium amount. Your change in coverage will be activated after we receive your first month's premium payment, completed change application, and any other required documents.
- ✓ Please contact Customer Service, 8:30 a.m. to 5:30 p.m., EST, Monday-Friday (excluding holidays), at 517.364.8567 or 866.539.3342 with any questions.

PHP Agent Name _____ NPN Number _____

Physicians Health Plan

Change Form Instructions and Checklist

- ☐ Complete the entire form. An incomplete change form will be returned to you to complete. This may affect the start date of the changes you requested.
- ☐ Print clearly using black ink.
- ☐ Make changes online at:

  enroll.phpmichigan.com

  You can also setup automatic premium payments with the online tool.

- ☐ Please be advised when adding or removing a dependent, there may be a change in your monthly premium.

- ☐ Sign and date this form and return to PHP within **15 days of your signature date**.

  Return your completed form to Physicians Health Plan (PHP):

  Mail:

  Physicians Health Plan – Individual Enrollment

  P.O. Box 30377,

  Lansing, MI 48909-7877

  Fax: 517.364.8416

  E-mail: PHP.Enrollment@phpmm.org

  Contact: Customer Service
  Monday-Friday
  8:30 a.m. to 5:30 p.m., EST (excluding holidays)
  517.364.8567 or 866.539.3342

Change Information

☐ Addition of Dependent(s)	Effective Date	
☐ Termination of Coverage for Policyholder	Effective Date	
☐ Termination of Coverage for Dependent(s)	Effective Date	

Physicians Health Plan

Change Information Continued

☐ Open Enrollment dates are: 11.01.2023 – 01.15.2024.

Completed applications received between 11.01.2023 – 12.15.2023 will have a policy with an effective date of 01.01.2024.

Completed applications received between 12.16.2023 – 01.15.2024 will have a policy with an effective date of 02.01.2024.

☐ Special enrollment due to life event Date of Event _____

Please provide documentation of life event.

☐ Marriage ☐ Divorce ☐ Birth ☐ Legal Guardianship ☐ Court or Administrative Order

☐ Death ☐ Adoption or Placement for Adoption ☐ Gain Citizenship

☐ Loss of Health Coverage* - Reason for loss of health coverage _____

**Voluntary loss of health coverage is not considered a life event*

Subscriber First Name _____ Last Name _____ Date of Birth _____

Legal Marital Status _____ Male ☐ Female ☐ Social Security Number _____

U.S. Citizen ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No

Tobacco User? ☐ Yes ☐ No (If interested in quitting please visit PHPMichigan.com, click on Members >> Take Charge of Your Health >> Disease Management).

Residential Address

Street Address _____

City _____

State _____ Zip Code _____

County _____ Phone Number _____

☐ Cell ☐ Work ☐ Home

Billing Address (if different from residential address)

Street Address _____

City _____

State _____ Zip Code _____

County _____ Phone Number _____

☐ Cell ☐ Work ☐ Home

Email Address _____

Physicians Health Plan

Plan Selection - all plans are HMO/Exclusive

Gold Classic ☐	Silver Select Plus ☐	Bronze HSA ☐
Gold Standard ☐	Silver Choice ☐	Bronze Standard ☐
Gold Select ☐	Silver Core ☐	Bronze ☐
	Silver Standard ☐	Catastrophic ☐
	Silver ☐	

Dependent Information (If Applicable)

You may only enroll:

- Your legal spouse (who resides with you)
- Dependent child less than 26 years of age
  - Natural child, stepchild, legally adopted child, child placed for adoption, child for whom legal guardianship has been awarded to the Applicant or the Applicant's legal spouse.
  - Unmarried dependent over the age of 26 who is disabled.

	Dependent Name	Social Security Number	Relationship to Applicant	Date of Birth	Gender
1					☐ Male ☐ Female
	☐ Add ☐ Terminate	U.S. Citizen ☐ Yes ☐ No	Permanent Resident of U.S. ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No	
2					☐ Male ☐ Female
	☐ Add ☐ Terminate	U.S. Citizen ☐ Yes ☐ No	Permanent Resident of U.S. ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No	
3					☐ Male ☐ Female
	☐ Add ☐ Terminate	U.S. Citizen ☐ Yes ☐ No	Permanent Resident of U.S. ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No	
4					☐ Male ☐ Female
	☐ Add ☐ Terminate	U.S. Citizen ☐ Yes ☐ No	Permanent Resident of U.S. ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No	
5					☐ Male ☐ Female
	☐ Add ☐ Terminate	U.S. Citizen ☐ Yes ☐ No	Permanent Resident of U.S. ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No	
6					☐ Male ☐ Female
	☐ Add ☐ Terminate	U.S. Citizen ☐ Yes ☐ No	Permanent Resident of U.S. ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No	

Physicians Health Plan

Coordination of Benefits

Failure to complete this section may result in delays in enrollment or claims payments.

On the day your coverage begins, will you or any family members be covered by other medical, dental, pharmacy, or Medicare insurance? ☐ Yes ☐ No

If yes, please complete the following section.

Name	Name of Policyholder	Policyholder's Date of Birth	Insurance Company Name & Phone Number	Policyholder's Employer (if applicable)

***If you are enrolled in or entitled to Medicare, you cannot be covered under the policy.**

Pediatric Dental Coverage Attestation – Required to Purchase This Policy

PHP benefit plans do not include pediatric dental coverage. If you want to cover a child under your plan, federal and state laws require you to purchase pediatric dental coverage offered by an Exchange-certified standalone dental plan to be eligible to purchase one of PHP's benefit plans.

PHP is required to obtain reasonable assurances from you that you have such coverage before PHP is permitted to sell you this health benefit plan. Therefore, please attest to the following:

- I understand that I am only eligible to purchase this PHP benefit plan if I also purchase pediatric dental coverage offered by an Exchange-certified standalone dental plan.
- I certify that I have purchased pediatric dental coverage offered by an Exchange-certified standalone dental plan.
- I will inform PHP immediately if this pediatric dental coverage is discontinued for any reason.
- I understand that if I am not truthful in this attestation, the PHP health benefit plan may be rescinded by PHP due to fraud or intentional misrepresentation of material fact, and that I may be required to reimburse PHP for any medical expenses that PHP paid on my (or my dependent's) behalf.

Signature

Date of Signature

Printed Name

*You do not need to sign this section if you are not covering a child under this plan.

Physicians Health Plan

Authorization and Signature

I understand and agree that coverage, if approved, will begin as specified above.

I understand that coverage will be provided under an individual contract. I understand that PHP does not issue individual coverage through any arrangement with an employer. PHP is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

I agree that if I am enrolling in a product that features certain designated providers, PHP may share my name, address, and telephone numbers, as well as my past, current, and future health and account records with such designated providers about service I have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

PHP primarily relies upon the information provided and full disclosure of the information listed on this enrollment form in the decision whether to accept the Applicant and/or dependent(s) listed on this enrollment form for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the enrollment form, even if the Applicant, and/or dependent(s) listed on this enrollment form, currently has coverage or had prior coverage with PHP.

I understand and agree that payment of a claim does not preclude the right of PHP to deny future claims or take any action it determines appropriate, including cancellation of the policy and seeking payment of claims already paid.

I agree to notify PHP immediately of any change in my, or my dependent(s), enrollment information between the date of this enrollment form and the effective date of coverage. Failure to notify PHP of any change in the information contained on this enrollment form may result in the denial of a claim, cancellation of the policy, or a premium adjustment.

Upon request, I agree to furnish additional information needed concerning eligibility of myself and/or any dependent(s) enrolling for coverage.

I have read the preceding instructions, statements, and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree PHP will act in reliance upon the information I have provided in this enrollment form, which materially affect enrollment eligibility may result in the denial of a claim(s), cancellation of the policy, or a premium adjustment.

Signature _____ Date of Signature _____

Printed Name _____

Applicant, Parent, Legal Guardian or Guarantor Signature (if contract holder is a minor)

Payment Information

- Your invoice will be mailed after the 3rd of the month
- Your payment is due by the last day of the month for the following month's coverage.
- You may pay electronically at ChoosePHPMI.com.

PHYSICIANS HEALTH PLAN (PHP)

PRIMARY CARE PROVIDER (PCP) SELECTION FORM

517.364.8567 or 866.539.3342

1. Please select a PRIMARY CARE PROVIDER (PCP) for each member of your family. A listing of current physicians is available on our website at www.PHPMichigan.com. You can tell us your PCP by visiting our member portal, MyPHP, by visiting the PHP Website.

2. If you are choosing a ***NEW*** provider, please call them to schedule an initial appointment.

3. Please return this form, call PHP, or use our online portal, MyPHP, to tell us your physician selection(s) as soon as possible. A delay could cause problems in receiving medical care.

4. WHEN YOU NEED MEDICAL CARE, CALL YOUR PCP FIRST. IDENTIFY YOURSELF AS A PHP MEMBER. All of your medical care must be coordinated by your PCP, except for emergencies.

Please Print Clearly

SUBSCRIBER NAME: FIRST:_____ LAST: _____

PHP ID#: _____PHONE NUMBER: _____

ADDRESS:_____

List the names of each enrolled family member (*list dependents in birth order from oldest to youngest*) and the for each:

MEMBER NAME (enrolled in PHP)	**BIRTH DATE**	**PRIMARY PHYSICIAN**	**PHYSICIAN OFFICE ADDRESS**
Subscriber:			
Spouse:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			

Non-Discrimination

Physicians Health Plan (PHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PHP 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); and provides free language services to people whose primary language is not English, such as qualified interpreters; and information written in other languages. If you need these services, contact Customer Service at 800.832.9186 (TTY 711). If you believe that PHP 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 with the PHP Civil Rights Coordinator, mailing address: PO Box 30377 Lansing MI 48909-7877, phone: 800.832.9186, (TTY 711), fax: 517.364.8406 email: PHPCompliance@phpmm.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PHP Civil Rights Coordinator is available to help you. 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, 1.800.368.1019, 800.537.7697 (TTD). Complaint forms are available at http://www.HHS.gov/ocr/office/file/index.html.

Language Access Services

This Notice has Important Information. This notice has important information about your application or coverage through PHP. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 517.364.8500 - 800.832.9186 (TYY: 711).

Spanish Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PHP. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 517.364.8500 - 800.832.9186 (TTY: 711).

Arabic

للاخ نم ةيطغتلا ىلع لوصحلل كبلط صوصخب ةمهم تامولعم راعشلاا اذه يوحي .ةماه تامولعم راعشلاا اذه يوحي PHP,
يف ةدعاسملا وا ةيحصلا كتيطغت ىلعظافحلل ةنيعم خيراوت يف ءارجا ذاختلا جاتحت دق .راعشلاا اذه يف ةماهلا خيراوتلا نع ثحبا
بلصتا .ةفلكت يأ نود نم كتغلب ةدعاسملاو تامولعملا ىلع روصحلا يف قحلا كل .فيلاكتلا 517.364.8500 - 800.832.9186 (TTY: 711).

Chinese 本通知有重要的訊息。本通知有關於您透過[插入SBM 項目的名稱 PHP 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話[在此插入數字517.364.8500 - 800.832.9186 (TTY: 711).

German Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch PHP. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 517.364.8500 - 800.832.9186 (TTY: 711).

Italian Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso PHP. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 517.364.8500 - 800.832.9186 (TTY: 711).

Japanese この通知には重要な情報が含まれています。この通知には、PHPの申請または補償範 囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康 保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご 希望の言語による情報とサポートが無料で提供されます。517.364.8500 - 800.832.9186 (TTY: 711) までお電話ください。

Korean 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PHP을 통한 커버리지 에 관한 정보를 포함하고 있습니다.

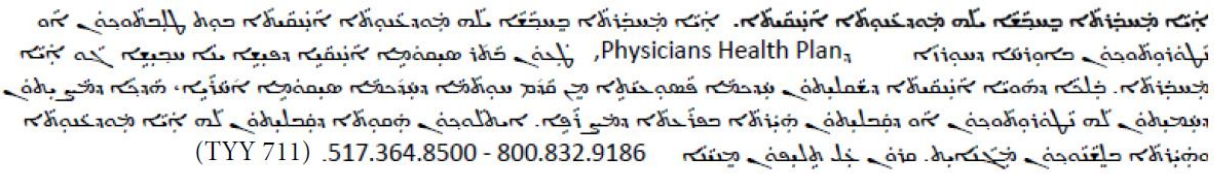
본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 517.364.8500 - 800.832.9186 (TTY: 711) 로 전화하십시오.

Polish To ogłoszenie zawiera ważne informacje.To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez PHP.Prosimy zwrócic uwagę na kluczowe daty zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 517.364.8500 - 800.832.9186 (TTY: 711).

Russian Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через PHP. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно,

потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 517.364.8500 - 800.832.9186 (TTY: 711).

Syriac



Tagalog Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PHP. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 517.364.8500 - 800.832.9186 (TTY: 711).

Vietnamese Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình PHP. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 517.364.8500 - 800.832.9186 (TTY: 711).

Bengali গুরুত্বপূর্ে তথয আকে। এই নাটিকে আপার আকবিপত্র অথবা কভাকরজ মাযিম সম্পককে গুরুত্বপূর্ে তথয রকয়কে PHP এই নাটিকের গুরুত্বপূর্ে তাদরখগুকলা নিখুি। আপাকক হয়কতা সুদিদিেষ্ট নকাি সময়সীমার নভতকর নকাি পিকেপ দিকত হকত পাকর আপার স্বাস্থ্য বীমা েলু রাখকত অথবা বযায় বহকির সাহাকযয। আপার অদিকার আকে দবিা খরকে আপার দিজস্ব ভাষাকত সাহাযয পাবার এবং তথয জাি বার। কল করুি 517.364.8500 - 800.832.9186 (TTY: 711).

Albanian Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet PHP. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin 517.364.8500 - 800.832.9186 (TTY: 711).

Serbo-Croatian U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PHP. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 517.364.8500 - 800.832.9186 (TTY: 711).