Clear Form

Send completed form to:
PHP
PO Box 853936
Richardson, TX 75805-3936
Or Fax to: 517.364.8416
ATTN: Enrollment Dept.

CHANGE FORM

Physicians Health Plan

Employee must sign this form for anything other than a termination of employment.

A. EMPLOYEE INFORMATION As it appears on ID Card

Employee's Last Name	First Name	Date of Birth	Social Security Number

B. EMPLOYEE CHANGES

Change Address to:	City	State	Zip

Change Name From:	Change Name to:

C. CHANGE IN COVERAGE

1. **ADDITIONS** ☐ Add Medical Coverage ☐ Add Dental Coverage	Qualifying Event Reason: ☐ Birth ☐ Adoption ☐ Marriage ☐ Loss of Coverage ☐ Other:	Effective. Date
2. **TERMINATIONS** ☐ All Coverage ☐ Medical ☐ Dental	☐ For employee and all covered dependents ☐ For dependents listed below	Reason: ☐ Termination ☐ Death ☐ Now Ineligible ☐ Divorce ☐ Dissatisfied ☐ Other: — Effective Date of Termination
3. **CHANGE** ☐ Change to COBRA Coverage ☐ Change from Class to Class	Reason for Change	Effective Date of Change

Please list family members to be covered under this policy. Please attach additional forms if needed. Write name as it should appear on ID Card. Dependent may not be eligible if other medical coverage is available to them through their employer.

	First Name M. I. Last Name	Social Security Number	Date of Birth	Gender	Relationship
☐ Add ☐ Delete ☐ Change				☐ Male ☐ Female	
☐ Add ☐ Delete ☐ Change				☐ Male ☐ Female	
☐ Add ☐ Delete ☐ Change				☐ Male ☐ Female	

B. COORDINATION OF BENEFITS Failure to complete this section may result in delays in enrollment or claim payments

On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance? ☐Yes ☐No **If yes, please complete this section and attach a copy of the card.** Please use extra paper if more than one additional policy will be in force.

Coverage type (please attach copy of other medical insurance care): ☐Medical ☐Dental ☐Prescription Drug ☐Medicare A/B ☐Medicare D	Name of Policy Holder	Policy Holder Date of Birth

Insurance Company Name & Phone Number	Policy Number and Eff. Date	Policy Holder's Employer

Medicare Policy Number	Medicare Part A Eff. date	Medicare Part B Eff. date	Medicare Part D Eff. date	Medicare Part C Eff. date

Reason for Medicare: ☐End Stage Renal Disease ☐Disability ☐Over age 65 ☐Over age 65 and working	List everyone covered by other insurance:	Coverage Dates

C. EMPLOYEE SIGNATURE this form must be signed by the employee even if waiving coverage

ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and or my dependents' coverage. NOTICE OF ENROLLMENT RIGHTS: I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may be able to enroll myself and my dependents in this policy if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, I can contact PHP Customer Service at 517.364.8500.

Employee Signature: Date Signed:

D. FOR EMPLOYER USE ONLY must be completed in order to process

Group Name	Group Number	Sub Group Number	Class Number	Effective Date
Qualifying event date	Qualifying event reason:	☐Full-time ☐Part-time	☐Union ☐Non-Union	☐Salaried ☐Hourly

Employer Representative Name: _____ Phone Number: _____

Employer Representative Signature: Date: