CLEAR FORM

PHP Agent Name

_____

NPN #

_____

*Individual Health Enrollment **CHANGE FORM** (Off-Marketplace)*

ENROLLMENT CHANGE FORM INSTRUCTIONS

1. Please complete this entire enrollment change form. **Print clearly using black ink**. An incomplete enrollment change form will be returned to you to be completed. This may affect the date your coverage starts.

2. Sign and date this form. This enrollment change form must be received at PHP within 15 days of your signature.

3. Mail your completed form to: Physicians Health Plan – Individual Enrollment, PO Box 30377, Lansing, MI 48909-7877 or fax to: 517.364.8416 or e-mail to: php.enrollment@phpmm.org.

4. A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on PHP's website – phpmichigan.com or available free of charge when requested by calling the phone number listed in the How to Contact Us section.

ENROLLMENT CHANGE FORM INSTRUCTIONS

- You must reside in PHP's service area – Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, and Shiawassee counties, or in one of the following zip codes in Montcalm County – 48811, 48818, 48829, 48834, 48838, 48852, 48891, 48884, 48885, 48886, 48888.

- You must be a citizen of the United States (U.S.) or permanent resident. Proof of citizenship or permanent residency is required.

- Applicants age 20 and under applying for a Child Only Policy can only have single coverage.

- If eligible, coverage will be provided under an individual contract. PHP does not issue individual coverage through any arrangement with an employer.

- If you or a dependent is enrolled in, or entitled to Medicare, you/they are not eligible for this policy.

AFTER YOU SUBMIT YOUR ENROLLMENT CHANGE FORM

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

HOW TO CONTACT US

PHP Customer Service Specialists are happy to assist you Monday through Friday, 8:30 a.m. to 5:30 p.m. Call 517.364.8567 or 866.539.3342.

*Individual Health Enrollment **CHANGE FORM** (Off-Marketplace)*

☐ Addition of Dependent(s) – page 3	Effective Date:	
☐ Terminate Coverage	☐ Terminate Coverage for Policy Holder ☐ Terminate Coverage for Dependent(s) – page 3	Effective Date of Termination:
Change from current plan to new plan ☐ Yes ☐ No	Effective Date of Change:	

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

PLAN SELECTION – IF CHANGING CURRENT PLAN, PLEASE CHOOSE PLAN BELOW

Platinum 500	☐ Exclusive	Silver 2,000	☐ Exclusive	Silver 7,000	☐ Exclusive
	☐ HMO	Silver 2,500	☐ Exclusive	Bronze 5,500 HSA	☐ Exclusive
Gold 500	☐ Exclusive	Silver 2,800	☐ Exclusive	Bronze 6,650 HSA	☐ Exclusive
	☐ HMO	Silver 3,200 HSA	☐ Exclusive		☐ HMO
Gold 1,500	☐ Exclusive	Silver 4,000	☐ Exclusive	Bronze 7,300	☐ Exclusive
Gold 1,600 HSA	☐ Exclusive		☐ HMO	Bronze 7,900	☐ Exclusive
Gold 2,000	☐ Exclusive	Silver 4,200	☐ Exclusive		

GENERAL INFORMATION

Subscriber Name:_____ Legal Marital Status: ☐ Single ☐ Married

Subscriber Number:_____

Social Security Number:_____ Birthdate:_____ ☐ Male ☐ Female

U. S. Citizen? ☐ Yes ☐ No Permanent resident of the U.S.? ☐ Yes ☐ No
Tobacco User? ☐ Yes ☐ No (If you are interested in quitting, please visit phpmichigan.com)

*Individual Health Enrollment **CHANGE FORM** (Off-Marketplace)*

Subscriber Address:

Street:_____

City:_____

State:_____ Zip:_____

County:_____

Billing Address (if different):

Street:_____

City:_____

State:_____ Zip:_____

County:_____

Preferred Telephone:_____ ☐ Home ☐ Cell ☐ Work

Alternate Telephone:_____ ☐ Home ☐ Cell ☐ Work

Email Address:_____

DEPENDENT INFORMATION (IF APPLICABLE)

You may only enroll the following dependents – Your legal spouse (who resides with you), a dependent child (a natural child, a stepchild, a legally adopted child, a child placed for adoption, a child for whom legal guardianship has been awarded to the Applicant or the Applicant's legal spouse) less than 26 years of age, or an unmarried dependent over the age of 26 who is disabled.

	Name	Social Security #	Relationship to Applicant	Birthdate mm/dd/yyyy	Gender M/F
1					☐ Male ☐ Female
	☐Add ☐Delete U.S. Citizen? ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No			
2					☐ Male ☐ Female
	☐Add ☐Delete U.S. Citizen? ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No			
3					☐ Male ☐ Female
	☐Add ☐Delete U.S. Citizen? ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No			
4					☐ Male ☐ Female
	☐Add ☐Delete U.S. Citizen? ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No			
5					☐ Male ☐ Female
	☐Add ☐Delete U.S. Citizen? ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No			
6					☐ Male ☐ Female
	☐Add ☐Delete U.S. Citizen? ☐ Yes ☐ No	Tobacco User ☐ Yes ☐ No Permanent Resident of the U.S.? ☐ Yes ☐ No			

☐ Additional dependents on attached page

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

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

PEDIATRIC DENTAL COVERAGE ATTESTATION – REQUIRED TO PURCHASE THIS POLICY*

The PHP health benefit plans do not include pediatric dental coverage. If you want to cover a child(ren) 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 health 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 health 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 you may be required to reimburse PHP for any medical expenses that PHP paid on your (or your dependents) behalf.

Signed:_____ Date:_____

Printed Name:_____

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

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 have 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.

Signed:_____ Date:_____

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 www.choosephpmi.com.

PHYSICIANS HEALTH PLAN (PHP)

PRIMARY PHYSICIAN SELECTION FORM

PLEASE RETURN THIS FORM OR CALL PHP AS SOON AS POSSIBLE

517.364.8567 or 866.539.3342

1. Please select a PARTICIPATING PRIMARY PHYSICIAN (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*** physician, 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 PRIMARY PHYSICIAN FIRST. IDENTIFY YOURSELF AS A PHP MEMBER. All of your medical care must be coordinated by your Primary Physician, except for emergencies.

PLEASE PRINT CLEARLY

SUBSCRIBER NAME: LAST_____ FIRST _____

ADDRESS:_____

PHONE NUMBER:_____

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

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

LANGUAGE ASSISTANCE

This Notice has Important Information. This notice has important information about your application or coverage through Physicians Health Plan. 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 or 800.832.9186.

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.

Arabic

ي وحي اذه راع شلاا ت امول عم قماه. ي وحي اذه راع شلاا ت امول عم قمهم صو صخب ك ب لط ل و صح لل ى لع ةي ط غ تلا ن م ل لاخ PHP, ثحبا نع خيراوتلا قماهلا يف اذه راعشلاا. دق جاتحت ذاختلا ءارجا يف خيراوت ةنيعم ظافحلل بلع كتيطغت ةيحصلا وا ةدعاسملل يف ك تلادافليعف. كل ق حلا ي ف رو صحلا ى لع الت امول عم ةدعا سملاو ك تغ لب ن م ن ود ي أ كتةف ل. ل ص تا ـب 8500.364.517 - 9186.832.800.

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.

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.

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.

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 - 800.832.9186로 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.

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.

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.

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.

Bengali এইন িটিকে গুরুত্বপূর্ক তথয আকে । এইন িটিকে আনপার অোনিন পত্র অথিিা েভাোরজমান যম সম্পেকে গুরুত্বপ ূর্ক তথয

রেয়কেPHPএই ন িটিকের গুরুত্বপূর্ক তিাদরখগুেলি ন খুন।আনপ িাে েহয়েতিা সু নদদন ে ষ্ট েিান সময়সীমার ভতের েিান নপকেপ নদেত হেত পাের আনপার স্বিাস্থ্য য িীমাে িালু রিাখেতঅথিিা িিযায় িহনের সাহিাে যয। আনপার অনদেিার আকে দনিিা খরকে আনপার দন জস্ব ভাষিাে সাহিাযয পাি িার এিং তথয জ িান ি িার। েল েরুন 517.364.8500 -
800.832.9186.

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.

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.