PHP Insurance Company

New Group Checklist

30 days prior to the effective date, the following Group information is required:

- ❖ Group Policy Application completed and signed.
- ❖ Enrollment forms; be sure to complete any applicable COB information.
  - Include waivers for all eligible employees
- ❖ MESC/Quarterly Wage Detail Report (most current) – if enrollee is **NOT** on wage detail – please provide *proper tax returns* **&/or** copy of W4 and most recent pay stub.
  - **S Corporation –**
    - ✓ IRS Form 1120S (U.S. Income Tax Return for an "S" Corporation) and Schedule K-1 (Shareholders Share of Income, Credits, Deductions, etc.)
  - **Partnership/LLC –**
    - ✓ IRS Form 1065 (U.S. Partnership Return of Income) and Schedule K-1 (Shareholders Share of Income, Credits, Deductions, etc.). A Partnership Agreement is also acceptable with all partners names listed.
  - **Sole Proprietorship** –
    - ✓ Schedule C from proprietor's IRS form 1040
- ❖ Previous detailed carrier bill. *(if not applicable – will NEED tax returns)*
- ❖ HRA/HSA/FSA Attestation
- ❖ New Business Eligibility Verification Form
- ❖ Group Pediatric Dental Attestation form – *small group only*

When completing forms:

- ❖ Each Enrollment Form requires both employee and group contact signatures.
- ❖ Social Security numbers are required for all.
- ❖ Street address is required if employee uses a POB for mailing address.
- ❖ Please write legibly.

After PHP receives the initial materials above:

- ❖ The Final Rates page will be developed using the census information gathered from the member enrollment forms.
  - Once generated, PHP will send the Final Rates page back to the group contact/agent.
  - When signed by the agent or group contact it is to be sent back to PHP.
  - After the final rates are signed, the group will send a binder check to PHP for the first month of premium.
- ❖ Verify if employee packets or open enrollment meetings are required.
- ❖ Member ID cards.
  - It takes approximately three days for members to be enrolled in PHP's system.
  - Cards will be sent to the member's homes approximately 10 days after being entered into the system.

Physicians Health Plan

PHP Insurance Company

SMALL GROUP POLICY APPLICATION

HMO EXC ____ **POS** ____ **PPO** ____

(inititial please)

Company name to be listed on Policy

Effective Date of Coverage

Contact Person

Employer Taxpayer ID # _____

SIC Code _____

Street Address

City State Zip

County:

Phone Fax

( ) ( )

Mailing Addess (if different from Street Address)

City State Zip

MANDATORY

Email address: _____

Billing Contact Person (if different from above)

Street Address

City State Zip

Phone Fax

( ) ( )

Eligibility/Participation

How many total employees do you have_____
(including those who may not be eligible for coverage)

Total number of enrollees _____

Total number of waivers + _____

Total number of eligible employees = _____

Company Legal Status; *(i.e. S Corp, LLC, Partnership, etc)*

Premium Contribution

Indicate the % of premium, or the dollar amount, the employer contributes toward employee premium:

_____ **%**

Union Contract

Are any employees covered by a union contract? _____

Local # _____ Contract Exp. Date _____

Is the group currently a member of a sponsored association or chamber? _____

If yes, please indicate name of association or chamber: _____

Previous insurance coverage

Did your company have previous health insurance coverage? Yes _____ No _____

If yes, please indicate the name of the previous carrier _____

Is your current plan grandfathered under Health Care Reform? Yes _____ No _____

Dependent Age 26 Coverage Termination

End of Calendar Month: _____

End of Calendar Year: _____

DEDUCTIBLE ROLLOVER from PRIOR CARRIER

YES _____ **NO** _____

Must have information 21 days after effective date

Benefit Selection

Medical Benefit:	**Rx Benefit:**	**Delta Dental:** Yes No

Physicians Health Plan

PHP Insurance Company

Enrollment/Eligibility Criteria

Eligible for coverage:

ACTIVE: _____ Employee working a minimum of _____ hours per week.

_____ Other: _____

RETIREES: _____ *(not to exceed 10% of the active enrolled population)*

Excluded:

_____ Part time
_____ Temporary
_____ Seasonal
_____ Other _____

Effective Date for New Hires:

(NOT to exceed 91 days from date of hire)

____ Date of Hire

____ First of the month following _____ day waiting period

____ Date of completion of _____ day waiting period.

Effective Date for Return to Employment:

(NOT to exceed 91 days from date of return)

____ Date of Return

____ First of the month following _____ day waiting period

____ Date of completion of _____ day waiting period.

Effective Date for Status Change:

(NOT to exceed 91 days from date of change)

____ Date of Change

____ First of the month following _____ day waiting period

____ Date of completion of _____ day waiting period.

Effective Date for Termination of employment:

_____ Date of termination of employment

_____ Last day of the month in which termination occurs

The enrolling Group understands and agrees that if it signs this application and this application is accepted in writing by PHP, the Enrolling Group will be considered a Policyholder, and will be bound by the terms of such agreement, the provisions of PHP and the provisions of this application. The Enrolling Group acknowledges that these documents constitute the entire agreement between PHP, and the Enrolling Group, and supersede all prior or contemporaneous negotiations, representations, or agreements (whether written or oral) between the parties. PHP may, at its discretion, request supplemental information from any individual or company, including but not limited to information service agencies, medical or credit information bureaus.

The Enrolling Group certifies that the information contained in this application is accurate and agrees that issuance of coverage is based on this application, which shall become a part of the Policy. Any material omissions, misrepresentations or misstatements in the information requested on this form can result in voiding or reformation of insurance. By applying, the Enrolling Group agrees to all of the terms and conditions of this application, and all of the terms and provisions of the group insurance policy, as amended from time-to-time. Coverage will not become effective unless this application is accepted in writing by PHP.

Name of Producer _____ Agency _____

Printed Applicant Name _____ Applicant Signature _____

Applicant Title _____ Date _____

For Physicians Health Plan Use Only

Group Number _____ Sub Grp Number _____ Policy Effective Date _____ Sales Executive _____

Class _____ Description _____ Class _____ Description _____

Class _____ Description _____ Class _____ Description _____

Binder Check _____ Check Amount _____ Received _____

PHP Insurance Company

HRA/HSA/FSA ATTESTATION

Plan ID(s): _____

PLAN EFFECTIVE DATE: _____

PURPOSE:

The PHP Insurance Company coverage selected by the group is not attached to a Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). By signing below, you indicate that you understand and are not currently using or intend to use an HRA, HSA or FSA to fund your employees cost sharing responsibilities.

PLAN SPONSOR INFORMATION & ATTESTATION:

_____

Group Name

_____

Employer(s) Federal Identification Number

I, the undersigned, duly-authorized representative for

_____ ("Name of Group"), understand that I have selected a plan without an HRA or FSA attached that is not HSA compatible. I hereby attest that I will not fund an HRA, HSA or FSA and employees will be fully financially responsible for all member cost-sharing. I also acknowledge that by signing this attestation, I understand that knowingly giving incorrect information is considered a breach of contract with PHP Insurance Company and in such case, is cause for termination of our Group Policy.

_____

Group Representative Printed Name and Title

_____

Signature Date

_____

Producer Printed Name

_____

Producer Signature Date

Send completed forms to:
PHP Insurance Company
PO Box 853936,
Richardson, TX, 75085-3936
Or Fax to: (517) 364-8416
ATTN: Enrollment Department

Enrollment Form

PHP Insurance Company

PLEASE PRINT LEGIBLY

Application for: ☐ Medical ☐ Delta Dental

Waiver of Coverage: I decline coverage for:
☐ Employee & all dependents ☐ Spouse only ☐ Dependents only
Reason: ☐ Covered under another health plan ☐ Other (specify): _____

A. Employee & Family Information

Employee's Last Name	First Name	Middle Initial	Social Security Number
Street Address PO Box Apt. No.	City	State	Zip
Home Phone ( )	Work Phone ( )	Email @	Language preference
Date of Birth	Gender	Ethnicity	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Independent Contractor? ☐ Yes ☐ No	Primary Care Physician Last Name/First Initial City/Phone		Current Patient? Y / N

Please list family members to be covered under this policy. Please attach additional form if needed. Write name as it should appear on ID Card.

	First Name M.I. Last Name	Social Security Number	Relationship	Gender	Date of Birth	Primary Care Physician First & Last Name	Current Patient?
1							Y / N
2							Y / N
3							Y / N
4							Y / N
5							Y / N

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?
☐ **No** ☐ **Yes 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 card): ☐ Medical Insurance ☐ Medicare ☐ Dental Insurance	Name of Policy Holder	Policy Holder Date of Birth
Insurance Company Name & Phone Number	Policy Number	Policy Holder's Employer

Medicare Policy Number	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Part D Effective Date	Medicare Part C Effective Date
Reason for Medicare: ☐ End Stage Renal Disease ☐ Disability ☐ Over age 65 ☐ Over age 65 and working	Please 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 towards 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: ☐ Open Enrollment ☐ New Hire ☐ Return ☐ Status Change ☐ Other (Specify) _____	☐ Full Time ☐ Part Time	☐ Union ☐ Non Union	☐ Salaried ☐ Hourly

Employer Representative Printed Name: _____ Phone Number: _____

Employer Representative Signature **(required)**: _____ Date Signed:_____

For questions regarding this form, please e-mail – php.enrollment@phpmm.org or call the PHP Enrollment Department at (517) 364-8320

Send completed forms to:
PHP Insurance Company, PO Box 853936,
Richardson, TX, 75085-3936
Or Fax to: (517) 364-8416
ATTN: Enrollment Department

Change Form

PHP Insurance Company

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

A. Employee information (as it appears on ID Card)

First Name	Last Name	Social Security Number / /	Date of Birth / /

B. Employee Changes

Change Address to:

Change Name from: to:

C. Change in Coverage

1. Additions:
☐ Add Medical Coverage ☐ Add Dental Coverage

Qualifying event reason:
☐ Birth ☐ Adoption ☐ Marriage
☐ Loss of other coverage ☐ Other (specify): _____

Effective Date of Addition: / /

2. Terminations:
☐ All coverage ☐ Medical
☐ Dental

☐ For employee and all covered dependents
☐ For dependents listed below

Reason:
☐ Termination ☐ Death ☐ Now ineligible
☐ Divorce ☐ Dissatisfied ☐ Other (specify): _____

Effective Date of Termination:* / /

3. Changes:
☐ Change to COBRA coverage ☐ Change from Class _____ to Class _____

Reason

Effective Date of change / /

Please list family members to be added/deleted under this policy. Please attach additional form 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	Medical Insurance available from his/her employer?
☐Add ☐Delete ☐Change		/ /	/ /			
☐Add ☐Delete ☐Change		/ /	/ /			
☐Add ☐Delete ☐Change		/ /	/ /			

D. 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?
☐**No** ☐**Yes 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: ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare	Name of Policy Holder	Policy Holder Date of Birth / /
Insurance Company Name & Phone number	Policy Number	Policy Holder's Employer
Medicare Policy Number	Please list everyone covered by other insurance	Coverage Dates / /
Medicare Part A Effective date / /		
Reason for Medicare: ☐ End Stage Renal Disease ☐Disability ☐ Over age 65 ☐ Over age 65 and working	Medicare Part B Effective Date / /	Medicare Part C Effective Date / /
Medicare Part D Effective Date / /		

E. Employee Signature (this form must be signed by the employee unless canceling coverage due to employee termination)

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 towards 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 at 517.364.8500.

Employee Signature _____ Date Signed ____/____/____

F. For Employer Use Only – must be completed in order to process

Group Name	Group Number	Sub Group Number	Class Number	Effective Date / /

Employer Representative Printed Name: _____

Employer Representative Signature **(required)**: _____ Date Signed: ____/____/____

☐ * By checking this box, I certify that the affected individual was notified of the loss of coverage prior to the termination date.

For questions regarding this form, please e-mail – php.enrollment@phpmm.org or call the PHP Enrollment Department at (517) 364-8320

Physicians Health Plan

GROUP PEDIATRIC DENTAL COVERAGE ATTESTATION

The Physicians Health Plan or PHP Insurance Company group health benefit plan that you wish to purchase does not include pediatric dental coverage. Because of this, federal and state law provide that you are only eligible to purchase this group health benefit plan if you also purchase group pediatric dental coverage offered by an Exchange-certified standalone dental plan. PHP can assist you in obtaining group pediatric dental coverage offered by an Exchange-certified standalone dental plan.

Because you are only eligible to purchase this group health benefit plan if you also purchase group pediatric dental coverage from an Exchange-certified standalone dental plan, PHP is required to obtain reasonable assurances from you that you have such coverage before PHP is permitted to sell you this group health benefit plan. Therefore, please attest to the following:

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

Signature: _____ Date: _____

Printed Name: _____

Group Name: _____

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A Sparrow Subsidiary

1400 E. Michigan Avenue
P.O. Box 30377
Lansing, Michigan 48909-7877

T 517.364.8400
F 517.364.8460
phpmichigan.com

DISABLED DEPENDENT VERIFICATION FORM

Physician Certification

This form is used to certify physical or mental disability of a member for purposes of continued coverage with PHP. This form must be completed and signed by the member's treating physician. PHP reserves the right to request this certification on an annual basis.

Please Print:

Patient/Member Full Name:

Date of Birth:

Diagnosis:

Date of Diagnosis:

Is This Considered – Permanent ☐ Temporary ☐

Anticipated Course and/or Duration of Disability:

Describe the nature of the disability that results in the patient/member being incapable of self-support:
(Functional limitations, i.e., self care, understanding and use of language, learning, mobility, self direction, and capacity for independent living. Attributable to mental retardation such that the person has significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period; cerebral palsy, epilepsy, autism; or any retardation because this condition results in impairment in general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons. Please provide evidence of the individual's deficits in intellectual functioning or adaptive behavior.)

Physician's Name (please print):

Physician's Signature:

Date:

New Business Eligibility Verification Form

GROUP NAME: _____

Physicians Health Plan must obtain from a prospective employer group the number of eligible employees within each organization to ensure proper rating of the group.

Two key definitions that will be helpful in completing this form:

1. An *employer group* includes all offices, locations, or branches, whether or not employees at those sites are included under your healthcare contract with PHP.

2. An *eligible employee* includes an employee who works on a full-time basis with a normal workweek of 30 or more hours and may include those employees who work on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all employees and without regard to health status related factors. Do not include Retirees and COBRA participants in your eligible employee count.

Total number of employees entered on your Quarterly Wage Detail (IRS Form 941, Part 1, Line 1) – please include owners	
Total number of eligible employees	
Total number of employees NOT eligible for company sponsored healthcare coverage	
Total number of eligible employees declining coverage	
Does your company offer coverage with any other carrier? (Yes/No)	
If "Yes", please provide:	
# of eligible employees covered under other healthcare plan(s)	
The carrier(s) name	
Does your company offer retiree coverage? (Yes/No)	
If "Yes", please provide:	
# of retirees covered under company sponsored retiree healthcare plan(s)	
The carrier(s) name	

Authorized Group
Representative Signature _____

Printed Name _____

Title _____

Date _____

If you have questions regarding this form, please call your Account Executive at (517) 364-8484.