

Instructions
Enrollment / Change of Status Form
Contact Us with Questions

Call 517.364.8320

Email Form to: PHP.Enrollment@PHPMM.org

Mail Completed Form to: PHP-Physicians Health Plan PO Box 313 Glen Burnie, MD 21060-0313 Attn: Enrollment Department Fax Form To: 517.364.8416 Monday-Friday 8 a.m. to 5 p.m., EST Excluding Holidays

CHOOSING THE CORRECT FORM

Enrollment Form (page 2)

Please complete the enrollment form if you are a new subscriber.

Change Form (page 3)

The change form should be used to add or terminate a subscriber or dependents, or to make changes to a member's address, name or plan type.

INSTRUCTIONS



SECTION A Employee Information

Section A is required for both the Enrollment and Change of Status forms. Please enter your legal name and address. If you are filling out an Enrollment Form, please do not forget to enter the name, city, and state of your current Primary Care Provider (PCP).



SECTION B Covered Dependents (Enrollment Form)

Enter all covered dependents using the legal name of the dependent. You must also choose the gender, relationship, race, and ethnicity based upon the codes **SECTION B Form Codes**. Include the name of the Primary Care Physician (PCP).

Race is defined on *Merriam-Webster.com* as, "any one of the groups that humans are often divided into based on physical traits." Ethnicity is defined as your language and culture. For example, a person can be of the Black race, but their ethnicity is French.



SECTION B Change in Coverage (Change Form)

Additions: Check whether this is an addition to medical or dental coverage. Choose the qualifying event, and enter the effective date.

INSTRUCTIONS CONTINUED

Terminations: Check the type of coverage, who the termination affects, and the reason for the termination. Enter the effective date of the termination.

Changes: Check if COBRA coverage applies. Choose change, and the old/new class codes if you are changing plans.

Please add the names of all dependents that any changes apply to. Be sure to use their legal name.

You must also choose the type of change, gender, relationship, race, and ethnicity based upon the codes in the **SECTION B Form Codes** section.



SECTION C Coordination of Benefits

You must fill out this section. Choose "No" if you and your dependents are not covered by other health insurance, and proceed to the next section.

Choose "Yes" if you or your dependents are covered by another health insurance plan. You must fill out the entire section with the applicable details of the other health insurance policy. You must also include a copy of your insurance card.



SECTION D Employee Signature

You must sign and date this form.



SECTION E For Employer Use Only

DO NOT fill out anything in this section. Section E must be completed by the employer.



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Type of P		Plan HMO		PPO	ASO/	TPA	POS	E	PO	М	Member Enrollment			Medical		Denta		
SECTION A Employee Information - Please Enter Legal Name																		
							Name											
Street Address PO Box A								er	Ci	ity		S	tate	Zip Code				
Home Phone Number Email Address								Date of Birth						County				
Social Security Number Gender Male								e Marit	al Statu	ıs Div	orced Le	gally Separ	ated N	larried	Separat	ed	Single	
Ra	ice	American India	an or Alaska	Native Nati	ve Asian	Black or A	African Amer	ican	Multip	le Races	Other	White	Na	tive Ha	waiian or Pa	acific Is	lander	
Ethnicity Language Preference PCP																		
SECTION B Covered Dependents - Please Use Legal Name																		
	Last Na	ame		First Name	M.I.	Social Securi	ity	Gender Male	Female	Date of Birth	Relation Wife	ship Husband	Daughter	Son	Life Doubles	Other		
1	Race	American Indian or	· Alacka Nativo	Asian	Black or African An	norican Nati	ve Hawaiian or			 Multiple Race		White Ethr		3011	Life Partner PCP	Other		
-	Nace	American mulan or	Alaska Ivative	Asiaii	DIACK OF AFFICAL AF	IVAL	ve nawaliali oi	Male	Female		Wife	Husband	Daughter	Son	Life Partner	Other		
2	Race	American Indian or	Alaska Native	Asian	Black or African Ar	nerican Nat	ive Hawaiian or			Multiple Race		White Ethr		30.1	PCP	- Ctilici		
								Male	Female		Wife	Husband	Daughter	Son	Life Partner	Other		
3	Race	American Indian or	Alaska Native	Asian	Black or African Ar	nerican Nat	ive Hawaiian or	Pacific Islan	ider l	Multiple Race	s Other	White Ethr	nicity		PCP			
4								Male	Female		Wife	Husband	Daughter	Son	Life Partner	Other		
	Race	American Indian or		Asian	Black or African Ar	nerican Nat	ive Hawaiian or	Pacific Islan	ider l	Multiple Race	s Other	White Ethr	nicity		PCP			
	SECTION	ON C Coordination	n of Benefits															
Do You or Your Family Have Any Other Healthcare Coverage? No Yes – Please Complete This Section Medical Medicare																		
Ро	licyhold	ler Name				Date of Birt	h	Effective	Date o	of Policy	Phone Number							
Em	nployer	Name			Insu	ırance Compa	any Name				Policy Number							
Me	edicare	Policy Number			R	eason for Me	edicare:	End Stag	e Renal	Disease	Disability Over A			Age 65 Over Age 65 And Working				
Medicare Effective Dates Part A Part B																		
SECTION D Employee Signature - Form Must Be Signed By the Employee Unless Coverage is Being Cancelled Due to Employee Termination																		
ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled in 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.																		
		EMPLOYEE S	SIGNATURE					DATE SIGNED										
SECTION E For Employer Use Only - This Section Must Be Completed In Order to Process the New Request																		
	oup Nai		•		Group Nu		ective Da		P	Plan Description								
Sub Group Number Class Number Delta Dental Group Nu																		
Qualifying Open Enrollment: Date New Hire: Date								Rehire: Date Return: Date Status						Change: Date				
Event Reason Other Date								l-Time	Part-T	ime Ac	tive Ret	ree Sal	laried F	lourly	Union	Non-l	Jnion	
Re	present	tative Printed N	ame				Represen	Representative Signature										
Re	present	tative Phone Nu	mber		Date Signed		-	J										
					•		•										-	



Change of Status Form

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Type of P	lan	нмо	PF	PO	ASO/T	PA	POS	E	PO												
SECTION A Employee Information – Please Enter Legal Name										Date of Birt	Oate of Birth Social Security Number										
Last Nan	ne								Fir	st Nam	е							IV	M.I.		
SECTION A.1 Employee Name and Address Changes																					
New Stre	New Street Address PO Box Apt Number											City		State Zip Code							
Old Name	е								New Name									County			
SECTION B Change in Coverage																					
Addition	s:	: Add Medical Coverage			Qualifyi	ng E	vent: E	Birth	h Adoption			Terminatio	ns:	All Cove	erage	Med	lical	Dental			
	_	Add Dental Coverage				Marria	Loss of Coverage			For:	Employee and All Covered Dependents Only Dependen				nandan	ts Listad!	Ralow				
Effective	Effective Date of Addition: Other												-	•		•			•		
Litective	Effective Date of Additions. Other											<u>Terminatio</u>	<u>Termination Reason:</u> Termination Death Divorce Now Ineligible								3
Changes: Change to Cobra Change from Class to Class											Dissatisfi	ied	Other		_	Last Day	of Coverag	e:			
List All Additions/Deletions. Use Legal Name and Use an Additional Form if Necessary																					
TOC	Last N						Name			M.I.	_	al Security	Ti	Date of Birth	Ethnicit	y	PCP	Gender	Relations	ship	
Add						l												Male	Wife	Husband	Daughter
1 Delete Change		American I	ndian or	Alaska Nati	ive Asi	ian	Black or Afr	ican Ameri	can N	ative Ha	waiian	or Pacific Island	der	Multiple Races	Other	White		Female	Son	Life Partn	er Other
Add																		Male	Wife	Husband	Daughter
2 Delete Change		American I	ndian or	Alaska Nati	ive As	ian	Black or Afr	ican Ameri	can N	ative Ha	waiian	or Pacific Island	der	Multiple Races	Other	White		Female	Son	Life Partne	
Add											I			·				Male	Wife	Husband	Daughter
3 Delete Change		American I	ndian or	Alaska Nati	ive As	ian	Black or Afr	ican Ameri	can N	ative Ha	waiian	or Pacific Island	der	Multiple Races	Other	White		Female	Son	Life Partne	er Other
Add																		Male	Wife	Husband	Daughter
4 Delete Change		American I	ndian or	Alaska Nati	ive As	ian	Black or Afr	ican Ameri	can N	ative Ha	waiian	or Pacific Island	der	Multiple Races	Other	White		Female	Son	Life Partne	er Other
	1	C Coordinat	tion of	Ronofite	Do V	OII 0	r Family F	lave Any	Other	Health	care	Coverage?	No	Yes – Plea	se com	oloto thi	s section	Medica	al De	ntal M	1edicare
Policyhol				Dellelles		50 0 .	uy		ate of		care	<u>`</u>	_	Date of Policy	•	nete tili	3 3000001	Phone Nu			
Employe							Inc	urance C					CLIVE	- i		lumber		i none ita			
Medicare								Reason f				End Stage	Pon		Disab		Over a	go 65 (lver age	e 65 and \	Morking
-		ive Dates		Part A					Part E			Liiu Stage	IVEII	ai Disease	Disab	iiity	Over a	ge 03 C	vei age	: 05 and 1	WOIKING
			o Signa			t Bo	Signed By				Cove	arago is Roin	a Cai	ncelled Due to	Employ	oo Torn	nination				
													_	that any omissions				ingly made h	y Hs on th	nis annlicati	ion may
invalida	te my ai	nd/or my depe	endents'	coverage. I	NOTICE O	OF ENF	ROLLMENT R	RIGHTS: I ur	ndersta	nd that if	l decli	ne enrollment f	or my	yself or my depend	dents (inc	luding my	spouse) be	cause of othe	r health c	coverage, I r	may be
														oyer stops contributed the coverage of the contribute of the coverage of the c							
		ge, birth, adop	otion or p	placement f	or adopti	on, I r	may be able	to enroll m	yself ar	nd my de	pende	nts. However, i	must	t request enrollme	ent withir	30 days	after the ma	rriage, birth,	adoption	or placeme	ent for
adoption. Employee Signature Date Signed																					
6 cr	TION				rl-:- C	••	NA D. A	0	-l I 0		D	Al Al	D				Date	Jigiieu			
SECTION E For Employer Use Only - This Section Must Be Completed In Order to Process the New Request Group Name Group Number L Effective Date Plan Description																					
Sub Grou		her	Class	s Number	<u> </u>	\neg	Employe				ted N		iive I	Date	Pla	וו שפאנו	ιριιστι				
		Phone Num		<u> </u>		世		•					of R	enresentative							
Date Sign							I certify that the affected individual was notified of Representative the loss of coverage prior to the termination date. Signature														