

Instructions Enrollment / Change of Status Form Contact Us with Questions Call 517.364.8320 Email Form to: PHP.Enrollment@PHPMM.org

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.

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

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.



Representative Phone Number

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Date Signed

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Type of Plan HM			мо	ю рро		ASO/TPA			POS			EPO			nber En	rollmen	t		Medica	al	Den		
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Но	ome Pho	one Nu	ımber		ddress				·					Date of Birth					County				
So	cial Sec	urity N	lumber			Gend	ler	Male	Fema	ale M	arita	al Status	s Di	ivorc	ced L	egally S	epara	ated N	Aarried	I Separa	ted	Single	
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SECTION B Covered Dependents - Please Use Legal Name																							
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Do	You or	Your	Family Have	Any Othe	r Healthca	re Coverage	e? I	No	Yes –	- Please	Comple	te Tl	his Secti	on		Medi	cal	Me	edicare				
Ро	Policyholder Name Date of Birt									Effective Date of Policy								Phor	ne Numb	er			
Em	nployer	Name					Insura	nce Co	Company Name						Policy Number								
M	edicare	Policy	Number		Reason for Medicare					End Stage Renal Disease					e Disability Ove				ver Age 65	er Age 65 And Workin			
M	edicare	Effect	ive Dates	Part		Part B										-							
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-	E 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																						
n	nay invali	date my	and/or my dep	endents' co	verage. NOT	ICE OF ENROLI	LMENT RI	GHTS: I u	Indersta	nd that if I	decline e	enroll	ment for I	myself or n	ny de	pendent	s (includi	ng my	spouse) be	cause of	other health o	overage	, I may
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SECTION E For Employer Use Only - This Section Must Be Completed In Order to Pro Group Name Group Number L													Dlan	n Descr	intion								
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Qualifying Open Enrollment: Date Event Reason Other						ſ	New Hire: Date Date				Rehire: Date			mo ^	Active Retiree			Sale		-	Union Non-Union		
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Date Signed

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Type of Plan	нмо	PP	A O	SO/TPA	A PC	DS .	EPO															
SECTION A Employee Information – Please Enter Legal Name										Date of Birth Social Security Number												
Last Name							Fir	st Nam	e				Ν	M.I.								
SECTION A.1 Employee Name and Address Changes																						
New Street Address PO Box Apt Number										City State Zip Code												
Old Name New Name											County											
SECTION B Change in Coverage																						
Additions:	Add Medical Coverage Qualifyi				g Event:	Birth	Adoption			Terminations: All Cov			Covera	ge	Med	dical I	Dental	ental				
	Add Den	tal Covera	age		Mai	rriage	Loss of Coverage			For:	novee and	overed Dependents Only				Dependents Listed Below						
Effective Da	te of Additio	on:			Oth	er	0							-								
			1							Termination Reason:			Termination Death			eath	Divorce	Now	Now Ineligible			
Changes:	Change to	o Cobra	Chang	e from	Class		to Class			Dissatisfied Other						Last Day	of Coverage:					
List All Additions/Deletions. Use Legal Name and Use an Additional Form if Necessary																						
	st Name			Fii	rst Name			M.I.	Socia	al Security		Date of Birth	Et	hnicity		РСР	Gender	Relation	ship			
Add 1 Delete																	Male	Wife	Husband	Daughter		
Change Ra	ce America	n Indian or	Alaska Native	e Asian	n Black or A	African Am	erican N	lative Ha	waiian	or Pacific Islan	der	Multiple Ra	ces O	ther	White		Female	e Son	Life Part	ner Other		
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	N C Coordir	nation of	Benefits	Do You	ı or Family	Have A	ny Other	Health	care	Coverage?	No	yes – F	lease	compl	ete th	is section	Medio	al De	ental M	Medicare		
Policyholder	Name				-		Date of				Effective Date of Policy Phor								e Number			
Employer Na	me				I	nsurance	e Compa	ny Nam	ne	•			Po	licy N	umber							
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Medicare Eff	ective Dates	5	Part A				Part I	3		v							<u> </u>	v		ŭ		
	ON D Employ	/ee Signat	ture – Form	n Must I	Be Signed	By the E	mployee	Unless	s Cove	erage is Bein	g Ca	ncelled Du	e to En	nploye	e Terr	nination						
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 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.																						
Employee Signature Date Signed																						
SECTION E For Employer Use Only - This Section Must Be Completed In Order to Process the New Request																						
Group Name						Group Nu				Effect				Plan	Descr	iption						
Sub Group Number Class Number Employee Representative Printed Name																						
Representative Phone Number I certify that the affected individual was notified of Representative																						

the loss of coverage prior to the termination date. Signature