



Change of Status Form

Contact Us with Questions

**UNIVERSITY OF MICHIGAN
HEALTH PLAN**

UNIVERSITY OF MICHIGAN HEALTH

Call 517-364-8320

Email Form to: Enrollment@UofMHealthPlan.org

Mail Completed Form to:

University of Michigan Health Plan

PO Box 313

Glen Burnie, MD 21060-0313

Attn: Enrollment Department

Fax Form To:

517-364-8416

Monday-Friday

8:00 a.m. to 5:00 p.m., ET

Excluding Holidays

Type of Plan	☐ HMO	☒ PPO	☐ POS	☐ EPO	First Name Thomas		Date of Birth 5/28/58	Social Security Number 379-72-9370					
SECTION A Employee Information - Please Enter Legal Name													
Last Name Fata					City Bonita Springs		State FL	Zip Code 34134					
SECTION B Change in Coverage													
Additions:		☐ Add Medical Coverage		☐ Birth		☐ Adoption		☐ All Coverage		☐ Medical		☐ Dental	
☐ Add Dental Coverage		☐ Marriage		☐ Loss of Coverage		☒ Other		☐ Termination		☐ Divorce		☐ Now Ineligible	
Effective Date of Addition:				Change from Class		to Class		Last Day of Coverage:					
Changes:		☐ Change to Cobra		☐ Change from Class									
List All Additions/Deletions. Use Legal Name and Use an Additional Form if Necessary													
TOC	Last Name	First Name	M.I.	Social Security	Date of Birth	Ethnicity	PCP	Gender	Relationship				
1	Add Lopez	Diego	S	633-25-6571	1/26/03	White		Male	Wife				
	Delete							Female	Husband				
	Change							Male	Son				
	Add							Female	Life Partner				
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