Physicians Health Plan

Instructions
Enrollment / Change of Status Form

Contact Us with Questions
Email PHP.Enrollment@PHPMM.org
Call 517.364.8320

Send 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.

SECTION B Form Codes

Type of Change
A = Add
D = Delete
C = Change

Gender Choices
M = Male
F = Female

Relationship Choices
S = Son
D = Daughter
H = Husband
W = Wife
LP = Life Partner
O = Other

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 and relationship based upon the codes in the **SECTION B Form Codes** section. Include the name of the Primary Care Physician (PCP).

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.

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, and relationship 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 Plan ☐ HMO ☐ PPO ☐ ASO/TPA ☐ POS ☐ EPO	Member Enrollment ☐ Medical ☐ Dental

SECTION A Employee Information - Please Enter Legal Name

Last Name	First Name	Middle Initial

Street Address	PO Box	Apt Number	City	State	Zip Code

Home Phone Number	Email Address	Date of Birth	County

Social Security Number	Gender ☐ Male ☐ Female	Marital Status ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ☐ Single

Primary Care Provider Name City & State of PCP	Ethnicity Language Preference

SECTION B Covered Dependents - Please Use Legal Name NOTE: You Must Answer if Dependent Has Other Insurance

Last Name	First Name	M.I.	Social Security	Date of Birth	Gender	Relationship	PCP Name	Is Medical Insurance Available to Dependent Through Employer?
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No

SECTION C Coordination of Benefits

Do You or Your Family Have Any Other Healthcare Coverage? ☐ No ☐ Yes – Please Complete This Section	☐ Medical ☐ Dental ☐ Medicare

Policyholder Name	Date of Birth	Effective Date of Policy	Phone Number

Employer Name	Insurance Company Name	Policy Number

Medicare Policy Number	Reason for Medicare: ☐ End Stage Renal Disease ☐ Disability ☐ Over Age 65 ☐ Over Age 65 And Working

Medicare Effective Dates	Part A	Part B	Part C	Part D

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 SIGNATURE _____ DATE SIGNED _____

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 Group Number	Class Number	Delta Dental Group Number

Qualifying Event Reason ☐ Open Enrollment ☐ New Hire ☐ Return ☐ Status Change ☐ Other	Date of Event

☐ Full-Time ☐ Part-Time	☐ Active ☐ Retiree	☐ Salaried ☐ Hourly	☐ Union ☐ Non-Union

Representative Printed Name	Representative Signature
Representative Phone Number / Date Signed	

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Type of Plan ☐ HMO ☐ PPO ☐ ASO/TPA ☐ POS ☐ EPO

SECTION A Employee Information – Please Enter Legal Name

Last Name	First Name	M.I.	Date of Birth	Social Security Number

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 ☐ Add Dental Coverage
Qualifying Event: ☐ Birth ☐ Adoption ☐ Marriage ☐ Loss of Coverage ☐ Other
Effective Date of Addition:

Changes: ☐ Change to Cobra ☐ Change from Class ____ to Class ____

Terminations: ☐ All Coverage ☐ Medical ☐ Dental
For: ☐ Employee and All Covered Dependents ☐ Only Dependents Listed Below
Termination Reason: ☐ Termination ☐ Death ☐ Divorce ☐ Now Ineligible ☐ Dissatisfied ☐ Other
Effective Date of Termination:

List All Additions/Deletions. Use Legal Name and Use an Additional Form if Necessary

Type of Change	Last Name	First Name	M.I.	Social Security Number	Date of Birth	Gender	Relationship	Is Medical Insurance Available Through Dependent Employer?
☐A ☐D ☐C						☐ M ☐ F	☐S ☐D ☐H ☐W ☐LP ☐O	☐Yes ☐No
☐A ☐D ☐C						☐ M ☐ F	☐S ☐D ☐H ☐W ☐LP ☐O	☐Yes ☐No
☐A ☐D ☐C						☐ M ☐ F	☐S ☐D ☐H ☐W ☐LP ☐O	☐Yes ☐No
☐A ☐D ☐C						☐ M ☐ F	☐S ☐D ☐H ☐W ☐LP ☐O	☐Yes ☐No

SECTION C Coordination of Benefits

Do You or Your Family Have Any Other Healthcare Coverage? ☐ No ☐ Yes – Please complete this section ☐ Medical ☐ Dental ☐ Medicare

Policyholder Name	Date of Birth	Effective Date of Policy	Phone Number

Employer Name	Insurance Company Name	Policy Number

Medicare Policy Number | Reason for Medicare: ☐ End Stage Renal Disease ☐ Disability ☐ Over age 65 ☐ Over age 65 and Working

Medicare Effective Dates	Part A	Part B	Part C	Part D

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 Number L	Effective Date	Plan Description

Sub Group Number	Class Number	Employee Representative Printed Name

Representative Phone Number	☐ I certify that the affected individual was notified of the loss of coverage prior to the termination date.	Representative Signature
Date Signed		