UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Enrollment Form

Contact Us with Questions
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 | Member Enrollment ☑ Medical ☑ Dental

SECTION A Employee Information - Please Enter Legal Name

Last Name Lucas	First Name Meredith	Middle Initial A				
Street Address 6150 W Michigan Ave	PO Box	Apt Number P7	City Lansing	State MI	Zip Code 48917	
Home Phone Number 2487521681	Email Address meredithlucas@outlook.com			Date of Birth 7/29/99	County Ingham	
Social Security Number 383-23-4580	Gender ☐ Male ☒ Female	Marital Status ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ☒ Single				
Race ☐ American Indian or Alaska Native Native ☐ Asian ☐ Black or African American ☐ Multiple Races ☐ Other ☒ White ☐ Native Hawaiian or Pacific Islander						
Ethnicity White	Language Preference English	PCP				

SECTION B Covered Dependents - Please Use Legal Name

	Last Name	First Name	M.I.	Social Security	Gender	Date of Birth	Relationship
1					☐ Male ☐ Female		☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White				Ethnicity		PCP
2					☐ Male ☐ Female		☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White				Ethnicity		PCP
3					☐ Male ☐ Female		☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White				Ethnicity		PCP
4					☐ Male ☐ Female		☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White				Ethnicity		PCP

SECTION C Coordination of Benefits

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

Policyholder Name Toni Shroeder	Date of Birth 11/09/66	Effective Date of Policy 1/1/2025	Phone Number
Employer Name Sumitomo Electric Wiring Systems	Insurance Company Name Anthem BCBS of Kentucky		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	

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 [signature] DATE SIGNED 2/7/2025

SECTION E For Employer Use Only - This Section Must Be Completed In Order to Process the New Request

Group Name LLPS, Inc.	Group Number L0001596	Effective Date 2-1-25	Plan Description Medical/Dental/Optical
Sub Group Number 1000	Class Number	Delta Dental Group Number DDPMI 5175 - Sub 1142	

Qualifying Event Reason: ☐ Open Enrollment: Date ☐ New Hire: Date ☐ Rehire: Date ☐ Return: Date ☐ Status Change: Date
☑ Other Coming off parent plan Date
☑ Full-Time ☐ Part-Time ☐ Active ☐ Retiree ☐ Salaried ☒ Hourly ☐ Union ☐ Non-Union

Representative Printed Name Michael Bishop	Representative Signature [signature]
Representative Phone Number 517 321 4144 Date Signed 2/11/25	