



Change of Status Form
Contact Us with Questions
Email PHP.Enrollment@PHPPMM.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

Type of Plan ☐ HMO ☐ PPO ☐ ASO/TPA ☐ POS ☐ EPO								
SECTION A Employee Information - Please Enter Legal Name								
Last Name <u>Connors</u>	First Name <u>Kathy</u>							
Date of Birth <u>3/30/93</u> Social Security Number <u>376-</u> M.I.								
SECTION A.1 Employee Name and Address Changes								
New Street Address	PO Box							
City	State							
Zip Code	County							
SECTION B Change in Coverage								
Old Name	New Name							
Additions: ☒ Add Medical Coverage ☐ Birth ☐ Adoption								
☒ Add Dental Coverage ☐ Marriage ☐ Loss of Coverage								
Effective Date of Addition: <u>4/1/23</u> ☐ Other								
Changes: ☐ Change to Cobra ☐ Change from Class ☐ to Class ☐								
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 Add ☐ C	<u>Connors</u>	<u>Zion</u>		<u>A. 014-96-87093</u>	<u>10/23</u>	<u>M</u>	<u>F</u> ☒ S ☐ D ☐ H ☐ W ☐ LP ☐ O	☐ Yes ☒ No
☒ A Add ☐ C	<u>Connors</u>	<u>Izabel</u>		<u>A. 699-43-2382</u>	<u>12/9/21</u>	<u>M</u>	<u>F</u> ☒ S ☐ D ☐ H ☐ W ☐ LP ☐ O	☐ Yes ☒ No
☐ A Add ☐ C						<u>M</u>	<u>F</u> ☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O	☐ Yes ☐ No
☐ A Add ☐ C						<u>M</u>	<u>F</u> ☐ 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								
Policyholder Name					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		Part A	
Medicare Effective Dates					Part B		Part C	
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 <u>LLPS, Inc.</u>		Group Number <u>10001596</u>		Effective Date <u>4-1-23</u>		Plan Description <u>Medical & Dental</u>		
Sub Group Number <u>1000</u>		Class Number		Employee Representative Printed Name <u>Michael Bishop</u>				
Representative Phone Number <u>517-321-4144</u>		☐ I certify that the affected individual was notified of Representative the loss of coverage prior to the termination date.		Signature <u>Michael Bishop</u>				
Date Signed <u>4/6/23</u>		N/A						