Physicians Health Plan

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

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

Type of Plan	☐ HMO	☐ PPO	☐ ASO/TPA	☐ POS	☐ EPO	Member Enrollment	☑ Medical	☑ Dental

SECTION A Employee Information - Please Enter Legal Name

Last Name Austin	First Name Daniel	Middle Initial D			
Street Address 1153 Runaway Bay Dr	PO Box	Apt Number 3B	City Lansing	State MI	Zip Code 48917
Home Phone Number 517-291-0181	Email Address daniela@llpsinc.com	Date of Birth 9/21/84	County Eaton		
Social Security Number 427-69-3646	Gender ■ Male ☐ Female	Marital Status ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ■ Single			
Primary Care Provider Name City & State of PCP			Ethnicity Caucasian Language Preference English		

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 [signature] DATE SIGNED 11/15/22

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	Plan Description
Sub Group Number 1000	Class Number	Delta Dental Group Number 5175	
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 Michael Bishop		Representative Signature [signature]	
Representative Phone Number 517-321-4144	Date Signed 11/17/22		