UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Change of Status 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

SECTION A Employee Information – Please Enter Legal Name

Last Name	First Name	M.I.	Date of Birth	Social Security Number
Fata	Thomas		5/28/58	379-72-9370

SECTION A.1 Employee Name and Address Changes

New Street Address	PO Box	Apt Number	City	State	Zip Code
24351 Woodsage Dr.			Bonita Springs	FL	34134

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
Last Day of Coverage:

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 ☐ Delete ■ Change	Fata	Susana		634-23-2411	5/24/79			☐ 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								
2 ☐ Add ☐ Delete ☐ Change								☐ 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								
3 ☐ Add ☐ Delete ☐ Change								☐ 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								
4 ☐ Add ☐ Delete ☐ Change								☐ 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								

SECTION C Coordination of Benefits

Do You or 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

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 2/20/25

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

Group Name	Group Number	Effective Date	Plan Description
LLPS, Inc.	L 0001596	2/01/25	

Sub Group Number 1000 | Class Number | Employee Representative Printed Name Michael Bishop
Representative Phone Number 517-321-4144
Date Signed 2/20/25
☐ I certify that the affected individual was notified of the loss of coverage prior to the termination date.
Representative Signature Michael Bishop