

Send completed forms to:
PHP Insurance Company, PO Box 853936,
Richardson, TX, 75085-3936
Or Fax to: (517) 364-8416
ATTN: Enrollment Department

Change Form



Employee must sign this form for anything other than a termination of employment.

A. Employee information (as it appears on ID Card)								
First Name <u>Destavious</u>	Last Name <u>Carr</u>	Social Security Number <u>382 94/3793</u>	Date of Birth <u>11/17/82</u>					
B. Employee Changes								
Change Address to:								
Change Name from: _____ to: _____								
C. Change in Coverage								
1. Additions: <input type="checkbox"/> Add Medical Coverage <input type="checkbox"/> Add Dental Coverage		Qualifying event reason: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> Other (specify): _____			Effective Date of Addition: / /			
2. Terminations: <input checked="" type="checkbox"/> All coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental		<input checked="" type="checkbox"/> For employee and all covered dependents <input type="checkbox"/> For dependents listed below			Reason: <input checked="" type="checkbox"/> Termination <input type="checkbox"/> Death <input type="checkbox"/> Now ineligible <input type="checkbox"/> Divorce <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Other (specify): _____			
					Effective Date of Termination:* <u>08/31/18</u>			
3. Changes: <input type="checkbox"/> Change to COBRA coverage <input type="checkbox"/> Change from Class _____ to Class _____ Reason _____ Effective Date of change / /								
Please list family members to be added/deleted under this policy. Please attach additional form if needed. Write name as it should appear on ID Card. Dependent may not be eligible if other medical coverage is available to them through their employer.								
	First Name	M.I.	Last Name	Social Security Number	Date of Birth	Gender	Relationship	Medical Insurance available from his/her employer?
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change				/ /	/ /			
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change				/ /	/ /			
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change				/ /	/ /			
D. Coordination of Benefits (Failure to complete this section may result in delays in enrollment or claim payments)								
On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If yes, please complete this section and attach a copy of the card. Please use extra paper if more than one additional policy will be in force.								
Coverage type: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Medicare				Name of Policy Holder		Policy Holder		
Insurance Company Name & Phone number				Policy Number		Policy Holder's Employer		Date of Birth / /
Medicare Policy Number		Please list everyone covered by other insurance			Coverage Dates / /		Medicare Part A Effective date / /	
Reason for Medicare: <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability <input type="checkbox"/> Over age 65 <input type="checkbox"/> Over age 65 and working				Medicare Part B Effective Date / /		Medicare Part C Effective Date / /		Medicare Part D Effective Date / /
E. Employee Signature (this form must be signed by the employee unless canceling coverage 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. To request special enrollment or obtain more information, I can contact PHP at 517.364.8500.								
Employee Signature _____							Date Signed / /	
F. For Employer Use Only - must be completed in order to process								
Group Name <u>Mandatory Poster</u>	Group Number <u>L0001596</u>	Sub Group Number <u>1000</u>	Class Number	Effective Date <u>8/31/18</u>				
Employer Representative Printed Name: <u>Michael Bishop</u>								
Employer Representative Signature (required): <u>Michael Bishop</u> Date Signed: <u>7/30/18</u>								
<input checked="" type="checkbox"/> * By checking this box, I certify that the affected individual was notified of the loss of coverage prior to the termination date.								
For questions regarding this form, please e-mail - php.enrollment@phpmm.org or call the PHP Enrollment Department at (517) 364-8320								