

Send completed form to:  
 PHP  
 PO Box 853936  
 Richardson, TX 75805-3936  
 Or Fax to: 517.364.8416 ATTN: Enrollment

## ENROLLMENT FORM



Application for:	<input checked="" type="checkbox"/> Medical	<input checked="" type="checkbox"/> Delta Dental	WAIVER OF COVERAGE. I decline coverage for: <input type="checkbox"/> Employee and all dependents <input type="checkbox"/> Spouse Only <input type="checkbox"/> Dependents Only Reason: <input type="checkbox"/> Covered under another health plan <input type="checkbox"/> Other:
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### A. EMPLOYEE & FAMILY INFORMATION

Employee's Last Name: <b>Stenzel</b>	First Name: <b>Joseph</b>	Middle Initial: <b>L</b>	Social Security Number: <b>376-02-0594</b>
Street Address <b>903 Maycroft Rd</b>	City: <b>Lansing</b>	State: <b>MI</b>	Zip: <b>48917</b>
Phone: <b>517-213-9398</b>	Work Phone: <b>517-321-4144</b>	Email: <b>josephstenzel7@gmail.com</b>	Language: <b>English</b>
Date of Birth: <b>04/07/86</b>	Gender: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <b>Caucasian</b>	Marital Status: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed <input type="checkbox"/> Separated
Primary Care Physician:	Last Name:	First Name:	City:

Please list family members to be covered under this policy. Please attach additional forms, 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	Relationship	Gender	Date of Birth	Medical Ins. Available from Employer?	Primary Care Physician
					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	

### B. 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No 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 (please attach copy of other medical insurance card): <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Name of Policy Holder:	Date of Birth:	
<input type="checkbox"/> Prescription Drug <input type="checkbox"/> Medicare A/B <input type="checkbox"/> Medicare D			
Insurance Co Name & Phone #:	Policy Number & Eff. Date:	Policy Holder's Employer:	
Medicare Policy #:	Medicare A Eff. Date:	Medicare B Eff. Date:	Medicare C Eff. Date:
Reason for Medicare: <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability	List everyone covered by other insurance and coverage dates:		
<input type="checkbox"/> Over age 65 <input type="checkbox"/> Over age 65 and working			

### C. EMPLOYEE SIGNATURE - This form must be signed by the employee even if waiving coverage

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 in this policy if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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 Customer Service at 517.364.8500.

Employee Signature: \_\_\_\_\_ Date Signed: **3-23-21**

### D. FOR EMPLOYER USE ONLY - must be completed in order to process

Group Name <b>LLPS, Inc.</b>	Group #: <b>L</b>	Sub-Group #: <b>1000</b>	Class #: <b>1000</b>	Eff. Date <b>04/21</b>
Qualifying event date: <b>03/01/21</b>	Qualifying Event Reason: <b>Management</b>	<input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Union <input type="checkbox"/> Salaried <input checked="" type="checkbox"/> Active	<input type="checkbox"/> COBRA	
		<input type="checkbox"/> Part-Time <input checked="" type="checkbox"/> Non-Union <input checked="" type="checkbox"/> Hourly <input type="checkbox"/> Retiree	<input type="checkbox"/> Surviving	
Employer Representative Name: <b>Michael Bishop</b>		Phone Number: <b>517-321-4144</b>		
Employer Representative Signature: <i>Michael Bishop</i>		Date: <b>03/23/21</b>		

For questions regarding this form, please e-mail php.enrollment@phpmm.org or call 517.364.8320