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

PHP Insurance Company

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

A. Employee information (as it appears on ID Card)

First Name	Last Name	Social Security Number	Date of Birth
Steven	Fata	364/82/5145	12 / 29 / 1962

B. Employee Changes

Change Address to:

Change Name from: to:

C. Change in Coverage

1. Additions: ☐ Add Medical Coverage ☐ Add Dental Coverage

Qualifying event reason: ☐ Birth ☐ Adoption ☐ Marriage ☐ Loss of other coverage ☐ Other (specify): ____

Effective Date of Addition: / /

2. Terminations: ☒ All coverage ☐ Medical ☐ Dental

☒ For employee and all covered dependents ☐ For dependents listed below

Reason: ☒ Termination ☐ Death ☐ Now ineligible ☐ Divorce ☐ Dissatisfied ☐ Other (specify): _____

Effective Date of Termination:* / /

3. Changes: ☐ Change to COBRA coverage ☐ 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?
☐Add ☐Delete ☐Change		/ /	/ /			
☐Add ☐Delete ☐Change		/ /	/ /			
☐Add ☐Delete ☐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?
☐**No** ☐**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: ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare	Name of Policy Holder	Policy Holder Date of Birth / /
Insurance Company Name & Phone number	Policy Number	Policy Holder's Employer
Medicare Policy Number	Please list everyone covered by other insurance	Coverage Dates / /
Medicare Part A Effective date / /		
Reason for Medicare: ☐ End Stage Renal Disease ☐ Disability ☐ Over age 65 ☐ 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	Group Number	Sub Group Number	Class Number	Effective Date
Mandatory Poster	0001596	1000	1000	/ /

Employer Representative Printed Name: Michael Bishop

Employer Representative Signature **(required)**: _____ Date Signed: ____/____/____

☐ * 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