

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

Enrollment Form

 PHP Insurance Company

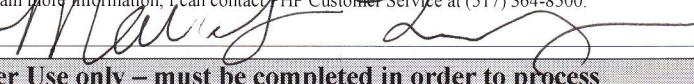
PLEASE PRINT LEGIBLY

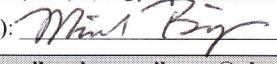
| | | | | |
|--|--|---|--|--|
| Application for: <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Delta Dental | | Waiver of Coverage: I decline coverage for: <input type="checkbox"/> Employee & all dependents <input type="checkbox"/> Spouse only <input type="checkbox"/> Dependents only Reason: <input type="checkbox"/> Covered under another health plan <input type="checkbox"/> Other (specify): _____ | | |
|--|--|---|--|--|

| | | | | |
|---|--|----------------|--|---|
| A. Employee & Family Information | | | | |
| Employee's Last Name | First Name | Middle Initial | Social Security Number | |
| Street Address | PO Box | City | State | Zip |
| Home Phone (517) 898-1035 | Work Phone () | Email | Language preference | |
| Date of Birth 06-02-92 | Gender F | Ethnicity | Marital Status: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced |
| Independent Contractor? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Primary Care Physician 517-333-4100 | | | Current Patient? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| Last Name/First Initial | Cornerstone family practice East Lansing | | | Phone |

| | | | | | | | |
|---|------------|------|-----------|------------------------|--------------|--------|---------------|
| Please list family members to be covered under this policy. Please attach additional form if needed. Write name as it should appear on ID Card. | | | | | | | |
| 1 | First Name | M.I. | Last Name | Social Security Number | Relationship | Gender | Date of Birth |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |

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|---|--|--|--|--------------------------------|-----------------------------|--------------------------------|--|
| 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 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 (please attach copy of other medical insurance card): | | Name of Policy Holder | | | Policy Holder Date of Birth | | |
| <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Dental Insurance | | Policy Holder | | | | | |
| Insurance Company Name & Phone Number | | Policy Number | | Policy Holder's Employer | | | |
| Medicare Policy Number | | Medicare Part A Effective Date | | Medicare Part B Effective Date | | Medicare Part D Effective Date | |
| Reason for Medicare: <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability <input type="checkbox"/> Over age 65 | | Please list everyone covered by other insurance: | | | | Coverage Dates: | |

| | | | | | | | |
|---|--|--------------------|--|--|--|--|--|
| 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 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 Customer Service at (517) 364-8500. | | | | | | | |
| Employee Signature  | | Date Signed 1/5/18 | | | | | |

| | | | | | | | |
|---|---|---------------|--|--|--|---|--|
| D. For Employer Use only – must be completed in order to process | | | | | | | |
| Group Name: | | Group Number: | | Sub Group Number | | Class Number | |
| Effective Date: 1/ | | | | | | | |
| Qualifying event date | Qualifying event reason: <input checked="" type="checkbox"/> Open Enrollment <input checked="" type="checkbox"/> New Hire <input type="checkbox"/> Return <input type="checkbox"/> Status Change <input type="checkbox"/> Other (Specify) _____ | | | <input checked="" type="checkbox"/> Full Time <input type="checkbox"/> Part Time | | <input type="checkbox"/> Union <input checked="" type="checkbox"/> Non Union <input type="checkbox"/> Salaried <input checked="" type="checkbox"/> Hourly | |
| Employer Representative Printed Name: Michael Bishop | | | | Phone Number (517) 321-4144 X355 | | | |
| Employer Representative Signature (required):  | | | | Date Signed: 1/5/18 | | | |

For questions regarding this form, please e-mail – php.enrollment@phpmi.org or call the PHP Enrollment Department at (517) 364-8320

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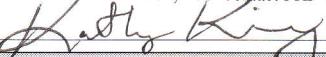
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|---|--|---|--|--|

| | | | | |
|---|---------------------------|--------------------------------|---|------------------------|
| A. Employee & Family Information | | | | |
| Employee's Last Name | First Name | Middle Initial | Social Security Number | |
| King | Kathy | E | 376-15-7118 | |
| Street Address | PO Box | City | State | Zip |
| 425 S. Holmes St. | | Lansing | MI | 48912 |
| Home Phone (734) 775-6517 | Work Phone (877) 321-4144 | Email King.kathy11 @ gmail.com | Language preference English | |
| Date of Birth 03/30/93 | Gender F | Ethnicity Black | Marital Status: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated | Divorced |
| Independent Contractor? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Primary Care Physician | | | Current Patient? Y / N |
| Last Name/First Initial | | | City/Phone | |

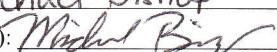
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| Please list family members to be covered under this policy. Please attach additional form if needed. Write name as it should appear on ID Card. | | | | | | | | |
| 1 | First Name | M.I. | Last Name | Social Security Number | Relationship | Gender | Date of Birth | Primary Care Physician First & Last Name |
| 2 | | | | | | | | Y / N |
| 3 | | | | | | | | Y / N |
| 4 | | | | | | | | Y / N |
| 5 | | | | | | | | Y / N |

| | | | | | | | | |
|---|--|--------------------------------|--|--------------------------------|--------------------------|--------------------------------|--|--------------------------------|
| B. Coordination of Benefits – (Failure to complete this section may result in delays in enrollment or claim payments) | | | | | | | | |
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| Coverage type (please attach copy of other medical insurance card): <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Dental Insurance | | | Name of Policy Holder | | | Policy Holder Date of Birth | | |
| Insurance Company Name & Phone Number | | | Policy Number | | Policy Holder's Employer | | | |
| Medicare Policy Number | | Medicare Part A Effective Date | | Medicare Part B Effective Date | | Medicare Part D Effective Date | | Medicare Part C 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 | | | Please list everyone covered by other insurance: | | | | | Coverage Dates: |

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| 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 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 Customer Service at (517) 364-8500. | | | | | | | | |

Employee Signature  Date Signed 1/5/18

| | | | | | | | | |
|---|--|---------------|--|---|--|---|--|---|
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Employer Representative Printed Name: Michael Bishop Phone Number: (517) 321-4144 X350
 Employer Representative Signature (required):  Date Signed: 1/5/18

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