Physicians Health Plan

Enrollment Form
Contact Us with Questions
Email PHP.Enrollment@PHPMM.org
Call 517.364.8320

Mail Completed Form to:
PHP-Physicians Health Plan
PO Box 313
Glen Burnie, MD 21060-0313
Attn: Enrollment Department

Fax Form To:
517.364.8416
Monday-Friday
8 a.m. to 5 p.m., EST
Excluding Holidays

Type of Plan	☐ HMO	☐ PPO	☐ ASO/TPA	☐ POS	☐ EPO	Member Enrollment	☑ Medical	☑ Dental

SECTION A Employee Information – Please Enter Legal Name

Last Name	First Name	Middle Initial
Austin	Daniel	D

Street Address	PO Box	Apt Number	City	State	Zip Code
1153 Runaway Bay Dr		3B	Lansing	MI	48917

Home Phone Number	Email Address	Date of Birth	County
517-291-0181	daniela@llpsinc.com	9/21/84	Eaton

Social Security Number: 427-69-3646
Gender: ■ Male ☐ Female
Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ■ Single

Primary Care Provider Name
City & State of PCP
Ethnicity: Caucasian
Language Preference: English

SECTION B Covered Dependents – Please Use Legal Name NOTE: You Must Answer If Dependent Has Other Insurance

Last Name	First Name	M.I.	Social Security	Date of Birth	Gender	Relationship	PCP Name	Is Medical Insurance Available to Dependent Through Employer?
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No
					☐ M ☐ F	☐ S ☐ D ☐ H ☐ W ☐ LP ☐ O		☐ Yes ☐ No

SECTION C Coordination of Benefits

Do You or Your 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	Part C	Part D

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 in 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.

EMPLOYEE SIGNATURE: Daniel Austin DATE SIGNED: 11/15/22

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	L0001596	12/1/22	

Sub Group Number	Class Number	Delta Dental Group Number
1000		5175

Qualifying Event Reason: ☐ Open Enrollment ☐ New Hire ☐ Return ☑ Status Change ☐ Other Date of Event

☑ Full-Time ☐ Part-Time ☑ Active ☐ Retiree ☐ Salaried ☑ Hourly ☐ Union ☑ Non-Union

Representative Printed Name	Representative Signature
Michael Bishop	Michael Bishop

Representative Phone Number: 517-321-4144 Date Signed: 11/17/22