Physicians Health Plan

Change of Status Form

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

Send 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

SECTION A Employee Information – Please Enter Legal Name | Date of Birth | Social Security Number

Last Name: Fata | First Name: Paul | M.I.:

SECTION A.1 Employee Name and Address Changes

New Street Address | PO Box | Apt Number | City | State | Zip Code

Old Name | New Name | County

SECTION B Change in Coverage

Additions: ☐ Add Medical Coverage ☐ Add Dental Coverage
Qualifying Event: ☐ Birth ☐ Adoption ☐ Marriage ☐ Loss of Coverage ☐ Other
Effective Date of Addition:

Changes: ☐ Change to Cobra | ☐ Change from Class ____ to Class ____

Terminations: ☒ All Coverage ☒ Medical ☒ Dental
For: ☐ Employee and All Covered Dependents ☐ Only Dependents Listed Below
Termination Reason: ☐ Termination ☒ Death ☐ Divorce ☐ Now Ineligible
☐ Dissatisfied ☐ Other ____ Effective Date of Termination: ____

List All Additions/Deletions. Use Legal Name and Use an Additional Form if Necessary

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

Employee Signature ____ Date Signed ____

SECTION E For Employer Use Only - This Section Must Be Completed In Order to Process the New Request

Group Name: LLPS, Inc. | Group Number: L0001596 | Effective Date: 11/1/22 | Plan Description

Sub Group Number: 1000 | Class Number | Employee Representative Printed Name: Michael Bishop

Representative Phone Number: 517-321-4144 | ☒ I certify that the affected individual was notified of the loss of coverage prior to the termination date. | Representative Signature: Michael Bishop

Date Signed: 11/1/22