Physicians Health Plan

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

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 Stark	First Name Samuel	Middle Initial E			
Street Address 108 S. Hosmer St.	PO Box	Apt Number 16	City Lansing	State MI	Zip Code 48912
Home Phone Number 989-292-1546	Email Address SamuelStark1@gmail.com	Date of Birth 04/21/1992	County Ingham		
Social Security Number 378156786	Gender ☑ Male ☐ Female	Marital Status ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ☑ Single			
Race ☐ American Indian or Alaska Native Native ☐ Asian ☐ Black or African American ☐ Multiple Races ☐ Other ☑ White ☐ Native Hawaiian or Pacific Islander					
Ethnicity	Language Preference	PCP			

SECTION B Covered Dependents - Please Use Legal Name

	Last Name	First Name	M.I.	Social Security	Gender	Date of Birth	Relationship
1					☐ Male ☐ Female		☐ Wife ☑ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White	Ethnicity		PCP			
2					☐ Male ☐ Female		☐ Wife ☑ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White	Ethnicity		PCP			
3					☐ Male ☐ Female		☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White	Ethnicity		PCP			
4					☐ Male ☐ Female		☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Life Partner ☐ Other
	Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multiple Races ☐ Other ☐ White	Ethnicity		PCP			

SECTION C Coordination of Benefits

Do You or Your Family Have Any Other Healthcare Coverage? ☐ No ☐ Yes – Please Complete This Section			☐ Medical ☐ 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	

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 Samuel Stark | DATE SIGNED 1/5/2024

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 1/1/24	Plan Description
Sub Group Number 1000	Class Number	Delta Dental Group Number	
Qualifying ☐ Open Enrollment: Date	☐ New Hire: Date	☐ Rehire: Date	☐ Return: Date ☐ Status Change: Date
Event Reason ☑ Other Off parents insurance Date	☑ Full-Time ☐ Part-Time	☑ Active ☐ Retiree	☐ Salaried ☑ Hourly ☐ Union ☐ Non-Union
Representative Printed Name Michael Bishop	Representative Signature Michael Bishop		
Representative Phone Number 517-321-4144	Date Signed 1/5/24		