UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Instructions
Enrollment / Change of Status Form

Contact Us with Questions
Call 517-364-8320
Email Form to: Enrollment@UofMHealthPlan.org

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

Fax Form To:
517-364-8416
Monday-Friday
8:00 a.m. to 5:00 p.m., ET
Excluding Holidays

CHOOSING THE CORRECT FORM

Enrollment Form (page 2)
Please complete the enrollment form if you are a new subscriber to a University of Michigan Health Plan (HMO) or University of Michigan Health Insurance Company (PPO) plan.

Change Form (page 3)
The change form should be used to add or terminate a subscriber or dependents, or to make changes to a member's address, name or plan type.

INSTRUCTIONS

SECTION A Employee Information

Section A is required for both the Enrollment and Change of Status forms. Please enter your legal name and address. If you are filling out an Enrollment Form, please do not forget to enter the name, city, and state of your current Primary Care Provider (PCP).

SECTION B Covered Dependents (Enrollment Form)

Enter all covered dependents using the legal name of the dependent. You must also choose the gender, relationship, race, and ethnicity**.** Include the name of the Primary Care Provider (PCP).

Race is defined on *Merriam-Webster.com* as, "any one of the groups that humans are often divided into based on physical traits." Ethnicity is defined as your language and culture. For example, a person can be of the Black race, but their ethnicity is French.

SECTION B Change in Coverage (Change Form)

Additions: Check whether this is an addition to medical or dental coverage. Choose the qualifying event, and enter the effective date.

INSTRUCTIONS CONTINUED

Terminations: Check the type of coverage, who the termination affects, and the reason for the termination. Enter the effective date of the termination.

Changes: Check if COBRA coverage applies. Choose change, and the old/new class codes if you are changing plans.

Please add the names of all dependents that any changes apply to. Be sure to use their legal name.

You must also choose the type of change, gender, relationship, race, and ethnicity in **SECTION B** for all dependents.

SECTION C Coordination of Benefits

You must fill out this section. Choose "No" if you or your dependents are not covered by other health insurance, and proceed to the next section.

Choose "Yes" if you or your dependents are covered by another health insurance plan. You must fill out the entire section with the applicable details of the other health insurance policy. You must also include a copy of your insurance card.

SECTION D Employee Signature

You must sign and date this form.

SECTION E For Employer Use Only

DO NOT fill out anything in this section. Section E must be completed by the employer.

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Type of Plan ☐ HMO ☐ PPO ☐ POS ☐ EPO	Member Enrollment ☐ Medical ☐ Dental

SECTION A Employee Information - Please Enter Legal Name

Last Name	First Name	Middle Initial

Street Address	PO Box	Apt Number	City	State	Zip Code

Home Phone Number	Email Address	Date of Birth	County

Social Security Number	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 _____ DATE SIGNED _____

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

Group Name	Group Number L	Effective Date	Plan Description
Sub Group Number	Class Number	Delta Dental Group Number	

Qualifying Event Reason ☐ Open Enrollment: Date ☐ New Hire: Date ☐ Rehire: Date ☐ Return: Date ☐ Status Change: Date
☐ Other Date ☐ Full-Time ☐ Part-Time ☐ Active ☐ Retiree ☐ Salaried ☐ Hourly ☐ Union ☐ Non-Union

Representative Printed Name	Representative Signature
Representative Phone Number / Date Signed	

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Excluding Holidays

Type of Plan ☐ HMO ☐ PPO ☐ POS ☐ EPO

SECTION A Employee Information – Please Enter Legal Name

Last Name	First Name	M.I.	Date of Birth	Social Security Number

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
Last Day of Coverage:

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

TOC	Last Name	First Name	M.I.	Social Security	Date of Birth	Ethnicity	PCP	Gender	Relationship
1 ☐ Add ☐ Delete ☐ Change								☐ 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									
2 ☐ Add ☐ Delete ☐ Change								☐ 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									
3 ☐ Add ☐ Delete ☐ Change								☐ 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									
4 ☐ Add ☐ Delete ☐ Change								☐ 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									

SECTION C Coordination of Benefits

Do You or 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

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	Group Number L	Effective Date	Plan Description

Sub Group Number | Class Number | Employee Representative Printed Name

Representative Phone Number
Date Signed
☐ I certify that the affected individual was notified of the loss of coverage prior to the termination date.
Representative Signature

We Speak Your Language

This Notice has important information about your application or coverage through UM Health Plan. Look for key dates in this Notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-832-9186 (TTY: 711).

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de UM Health Plan. Preste atención a las fechas importantes en este aviso. Es posible que deba tomar medidas antes de determinadas fechas para conservar su cobertura médica o ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-832-9186 (TTY: 711).

يحتوي هذا الإشعار على معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو التغطية من خلال "بي أتش بي." انظر الى التواريخ المُهمة في هذا الاشعار. قد تحتاج الى اتخاذ إجراء حسب المواعيد النهائية للحفاظ على التغطية الصحية أو المُساعدة في التكاليف. لديك الحق في الحصول على هذه المعلومات باللغة العربية دون أي تكلفة. اتصل على 800-832-9186 (TTY: 711)

本通知有重要的訊息。本通知有關於您透過[插入UM Health Plan 項目的名稱 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話[在此插入數字800-832-9186 (TTY: 711).

Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch UM Health Plan. Achten Sie auf die wichtigen Termine in dieser Benachrichtigung. Sie könnte sein, dass Sie bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten beizubehalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie unter 800-832-9186 (TTY: 711) an.

Questo avviso contiene informazioni importanti sulla sua domanda o copertura con UM Health Plan. Cerchi le date chiave in questo avviso. Potrebbe essere necessario un suo intervento entro una determinata scadenza per consentirle di mantenere la sua copertura o sovvenzione. Ha inoltre il diritto di ottenere queste informazioni e assistenza nella sua lingua gratuitamente. Chiama 800-832-9186 (TTY: 711).

この通知には、UM Health Planの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康 保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご 希望の言語による情報とサポートが無料で提供されます。800-832-9186 (TTY: 711))までお電話ください。

본통지서에는중요한정보가들어있습니다. 즉이통지서는귀하의신청에관하여그리고UM Health Plan을통한커버리지에관한정보를포함하고있습니다.
본통지서에서핵심이되는날짜들을찾으십시오. 귀하는귀하의건강보험 커버리지를계속유지하거나 비용을절감하기위해서일정한마감일까지어떤조치를취해야할필요가있을수있습니다. 귀하는귀하의언어로이러한정보와도움을비용부담없이얻을수있는권리가있습니다. 800-832-9186 (TTY: 711)로전화하십시오.

To ogłoszenie zawiera ważne informacje.To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń za pośrednictwem UM Health Plan. Prosimy zwrócić uwagę na kluczowe daty zawarte w tym ogłoszeniu, aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-832-9186 (TTY: 711).

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через UM Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-832-9186 (TTY: 711).

هذه المعلومات باللغة العربية دون أي تكلفة. اتصل على UM Health Plan ، يحتوي هذا الإشعار على معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو التغطية من خلال "بي أتش بي." انظر الى التواريخ المُهمة في هذا الاشعار. قد تحتاج الى اتخاذ إجراء حسب المواعيد النهائية للحفاظ على التغطية الصحية أو المُساعدة في التكاليف. لديك الحق في الحصول على
800.832.9186، (TTY: 711)

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong application o coverage sa pamamagitan ng UM Health Plan. Tingnan ang mga mahalagang petsa dito sa Paunawa. Maaaring kailangan mong gumawa ng aksyon bago ang mga partikular na takdang petsa upang mapanatili ang iyong coverage sa kalusugan o tulong sa mga gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong na nasa iyong wika nang walang bayad. Tumawag sa 5800-832-9186 (TTY: 711)

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình UM Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong
thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-832-9186 (TTY: 711).

এই বিজ্ঞপ্তিতে গুরুত্বপূর্ণ তথ্য রয়েছে। এই বিজ্ঞপ্তিতে UM Health Plan এর মাধ্যমে আপনার আবেদন বা কভারেজ সম্পর্কে গুরুত্বপূর্ণ তথ্য রয়েছে। মূল তারিখগুলি এই বিজ্ঞপ্তিতে সন্ধান করুন। আপনার স্বাস্থ্য কভারেজ বা খরচের বিষয়ে সাহায্যের জন্য আপনাকে নির্দিষ্ট সময়সীমার মধ্যে পদক্ষেপ নিতে হতে পারে। নিখরচায় আপনার ভাষায় এই তথ্য ও সাহায্য পাওয়ার অধিকার আপনার আছে। 800-832-9186 (TTY: 711).এ কল করুন।

Ky njoftim përmban informacione të rëndësishme. Ky njoftim përmban informacione të rëndësishme për aplikimin ose mbulimin tuaj shëndetësor nëpërmjet UM Health Plan. Kontrolloni datat e rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprime brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me pagesat. Ju keni të drejtë t'i merrni këto informacione si dhe ndihmë falas në gjuhën tuaj. Telefononi numrin 800-832-9186 (TTY: 711).

U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko UM Health Plan -a. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određene radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 800-832-9186 (TTY: 711).

Important Disclosure

University of Michigan Health Plan (UM Health Plan) complies with applicable Federal civil rights laws and does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, disability, sex, pregnancy, sexual orientation, gender identity, gender expression, religion, height, weight or veteran status. UM Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats); and provides free language services to people whose primary language is not English, such as qualified interpreters; and information written in other languages. If you need these services, contact Customer Service at 800.832.9186 (TTY 711). If you believe that UM Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by sending a complaint to:

University of Michigan Health Plan c/o Compliance
PO Box 30377
Lansing MI 48909-7877
phone: 800.832.9186, (TTY 711)
Compliance Hotline: 866.747.2667
fax: 517.364.8406
email: Compliance@UofMHealthPlan.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a Civil Rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
For additional information, please visit our website at www.uofmhealthplan.org