Send completed forms to:
PHPMM, PO Box 399,
Linthicum, MD, 21090-0399
Or Fax to: (517) 364-8280

Change Form

Physicians Health Plan of Mid-Michigan

Employee must sign this form for anything other than a termination of employment.

A. Employee information (as it appears on ID Card)

First Name	Last Name	Social Security Number	Date of Birth

B. Employee Changes

Change Address to:

Change Name from: to:

C. Change in Coverage

1. Additions:
☐ Add Medical Coverage ☐ Add Life/AD&D ☐ Add Long term disability
☐ Add Dental Coverage ☐ Add Short term disability

Qualifying event reason:
☐ Birth ☐ Adoption ☐ Loss of other coverage
☐ Marriage ☐ Other (specify):

2. Deletions:
☐ All coverage ☐ Dental ☐ LTD
☐ Medical ☐ Life ☐ STD

☐ For employee and all covered dependents
☐ For dependents listed below

Reason:
☐ Termination ☐ Death ☐ Now ineligible
☐ Divorce ☐ Dissatisfied ☐ Other (specify):

3. Changes:
☐ Change to COBRA coverage ☐ Change from Class__________to Class__________

Reason	**Effective Date**

Please list family members to be added/deleted under this policy. Please attach additional form if needed. Write name as it should appear on ID Card.
If adding dependent age 19 or over and they are an IRS dependent, please indicate in relationship field the relationship of dependent and "IRS".

Change	First Name M.I. Last Name	Social Security Number	Relationship	Gender	Date of Birth	Age 19 & over Full-time Student?	Primary Care Physician First & Last Name	Current Patient?
☐Add ☐Delete ☐Change						Y / N School Name:		Y / N
☐Add ☐Delete ☐Change						Y / N School Name:		Y / N
☐Add ☐Delete ☐Change						Y / N School Name:		Y / N

D. 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?
☐**No** ☐ **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: ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare	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

Reason for Medicare: ☐End Stage Renal Disease ☐ Disability ☐ Over age 65 ☐Over age 65 and working	Please list everyone covered by other insurance:	Coverage Dates:

E. Employee Signature (this form must be signed by the employee unless canceling coverage 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. To request special enrollment or obtain more information, I can contact PHPMM at 517.364.8500.

Employee Signature ____ Date Signed ____________________

F. For Employer Use Only

Group Name	Group Number	Sub Group Number	Class Number	Effective Date

Employer Representative Printed Name: ____

Employer Representative Signature (**required**): ____Date Signed:____________________

For Plan Use Only Subscriber ID:	Entered By:	Dept:	Date Entered:
Eligibility Level/Family Indicator:	Notes:		