McLaren HEALTH PLAN COMMUNITY

GROUP STATUS VERIFICATION FORM

Send completed form to:
Email: MHPSales@mclaren.org
Fax: 810-600-7931

To ensure timely and most accurate renewal, please verify that the following information is correct. Indicate changes/corrections or fill missing information in the space provided. Please forward to McLaren Health Plan Community with a copy of your most recent Quarterly Wage and Tax Statement filed with the State of Michigan.

	CURRENT	UPDATES/CORRECTIONS
Group name/number:	Group name: _____ Group number: _____	Group name: _____ Group number: _____
Group address:	Street: _____ City: _____ State: _____ Zip: ____	Street: _____ City: _____ State: _____ Zip: ____
Group contact:	Name: _____ Title: _____ Email address: _____	Name: _____ Title: _____ Email address: _____
Agent/agency of record:	Agent: _____ Agency of record:_____	Agent: _____ Agency of record:_____
Tax ID:	ID #:_____	ID #:_____
SIC code:	SIC code:_____	SIC code:_____
Employer contribution toward monthly premium: *(Employer contribution must be 50% or more of the single rate)*	Single %/$_____ Double %/$_____ Family %/$_____ Sponsored dependent %/$_____	Single %/$_____ Double %/$_____ Family %/$_____ Sponsored dependent %/$_____
Number of current waivers:	#: _____	#: _____
Number of current subscribers: *(Enrolled employees, enrolled retirees)*	Employees #: _____ Retirees #: _____	Employees #: _____ Retirees #: _____
Other employer sponsored health insurance:	Insurance company: _____	Insurance company: _____
Do you have a Collective Bargaining Agreement? ☐ Yes ☐ No	Union name: _____ # enrolled: _____	Union name: _____ # enrolled: _____
Employer funds portion of the deductible and/or coinsurance? ☐ Yes ☐ No	☐ HRA ☐ HSA ☐ FSA ☐ GAP Percentage / Employer Share / Employee Share Deductible: _____ _____ Coinsurance: _____ _____	☐ HRA ☐ HSA ☐ FSA ☐ GAP Percentage / Employer Share / Employee Share Deductible: _____ _____ Coinsurance: _____ _____

Name of person completing the form: _____ Email address: _____
(Printed) *(Printed)*

_____ Title: _____ Date: _____
Signature *(Printed)*

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McLarenHealthPlan.org