HEALTH PLAN

McLaren Health Plan
Group Status Verification Form

Part 1. GROUP INFORMATION

Today's Date:_________________________________**Group Number**: _________________________

Company Name:____

Contact Name:____

Phone #:_____________________________Fax #: ____

Email: ____________________________ Website: ___________________________________

Street Address:____

City: ____

Zip Code:______________________________State: ____

Tax ID #: ________________________________ Industrial Code (or SIC): _______________________

Type of Business: ____

Name of agent/broker (if applicable): ____

Worker's Compensation Carrier: ________________________________Policy #:___________________
Renewal Date: _________________________________
Total Number of Employees Eligible for Health Insurance: __________________________________
Total Number of Employees on Quarterly Wage Detail: ____________________________________

Full-time employees with a normal work week of 30 or more hours, or the total number of eligible employees the group may choose to include (employees working 17.5 to 30 hours per week), as long as this eligibility standard is applied uniformly to all employees without regard to health status.

Number of eligible employees NOT seeking coverage through any of your health plans: ____________

Number of eligible employees covered by a spouse, another employer, or a prior retirement plan: ____________

MHP requires those employees NOT seeking coverage to complete and sign the attached Waiver of Group Status Verification Form. Please ensure that all eligible employees waiving coverage through your group plan complete the form and return it to McLaren Health Plan, along with all required documents.

McLaren Health Plan (888) 327-0671
G-3245 Beecher Road, Flint, MI 48532
McclarenHealthPlan.org

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For those members enrolled in McLaren Health Plan, please enter the dollar amount or percent your company contributes on a monthly basis toward a one-person contract: $ _________or % _______of one-person contract cost.

If more than one carrier for health insurance, please complete:

Name of Carrier: ____
Number of Active Employees Enrolled: _______Retirees: _________COBRA: ________

Name of Carrier: ____
Number of Active Employees Enrolled: _______Retirees ________ COBRA: _______

Do you have a **Collective Bargaining Agreement?** Yes ☐ No ☐

Union Name: _________________________________Carrier Name: _______________________

Number Enrolled: __________

Union Name: _______________________________Carrier Name: _______________________
Number Enrolled: __________

Do you offer a **Self-Funded Program**? Yes ☐ No ☐

If yes: What benefits are offered? ____

Who is the Plan Administrator? ____

Number Enrolled: __________

Do you offer an **HRA or secondary policy** to cover any part of your deductible or coinsurance?

Yes ☐ No ☐

If yes, please describe the benefit: ____

Do you offer a **dental plan**? Yes ☐ No ☐

If yes, who is the Carrier? ____

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Name and Signature Required Below.

I affirm that the information provided on this form is true, accurate, and complete. I understand that the group agreement between McLaren Health Plan and the company may be terminated by McLaren Health Plan if I knowingly provided false information on this form.

Company Name:____

Signature: ____

Printed Name: ____

Title: ____

Date: ____________________

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