McLaren HEALTH PLAN COMMUNITY

NEW GROUP STATUS VERIFICATION FORM

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

Please email or fax this form, along with copies of your most recent Quarterly Wage and Tax Statement filed with the State of Michigan, and proof of Worker's Compensation coverage, to McLaren Health Plan Community.

	CURRENT
Group name/number:	Group name: _____
Group address:	Street: _____ City: _____ State: _____ Zip: _____
Group contact:	Name: _____ Title: _____ Email address: _____
Agent/agency of record:	Agent: _____ Agency of record: _____
Tax ID:	ID #: _____
SIC code:	SIC code: _____
Employer contribution toward monthly premium: *(Employer contribution must be 50% or more of the single rate)*	Single %/$_____ Double %/$_____ Family %/$_____
Number of current waivers:	#: _____
Number of current subscribers: *(Enrolled employees, enrolled retirees)*	Employees #: _____ Retirees #: _____ Eligible employees #: _____ Full time equivalents #: _____
Other employer sponsored health insurance:	Insurance company: _____
Do you have a Collective Bargaining Agreement? ☐ Yes ☐ No	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: _____ _____

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

_____ Title: _____ Date: _____
Signature (Printed)

G-3245 Beecher Road • Flint, Michigan • 48532
tel 888-327-0671 • fax 833-540-8648
McLarenHealthPlan.org