# ENROLLMENT/CHANGE FORM

McLaren HEALTH PLAN

## SECTION 1 — SUBSCRIBER INFORMATION - COMPLETE SECTION 1 - 4

| Social Security Number/Contract Number | Subscriber Last Name | Subscriber First Name | Middle Initial |
|---|---|---|---|
| | ☐ check if new | | |

| Street Address | City | State | Zip Code | County |
|---|---|---|---|---|
| ☐ check if new | | | | |

| Area Code | Home Phone Number | Area Code | Work Phone Number | Marital Status |
|---|---|---|---|---|
| | | | | ☐ Single ☐ Married ☐ Divorced ☐ Widowed |

## SECTION 2

**List All Persons to be Added or Deleted** | **Primary Care Physician Information (REQUIRED FOR EACH ENROLLEE)**

| Member Type | Select One | Last Name | First Name | Middle Initial | Gender | Date of Birth MM/DD/YYYY | Social Security Number | Relationship Code* | Last Name | First Name | City | Seen in last 12 months? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Subscriber | ☐ Add ☐ Delete | | | | ☐ M ☐ F | | | | | | | ☐ Y ☐ N |
| Spouse | ☐ Add ☐ Delete | | | | ☐ M ☐ F | | | | | | | ☐ Y ☐ N |
| Dependent 1 | ☐ Add ☐ Delete | | | | ☐ M ☐ F | | | | | | | ☐ Y ☐ N |
| Dependent 2 | ☐ Add ☐ Delete | | | | ☐ M ☐ F | | | | | | | ☐ Y ☐ N |
| Dependent 3 | ☐ Add ☐ Delete | | | | ☐ M ☐ F | | | | | | | ☐ Y ☐ N |

**If address of any dependent(s) listed above differs from the address in Section 1, please complete information below:**

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

Dependent(s) Residing at this Address

**Previous MHP or Health Advantage Affiliation**

Contract Number

*** Relationship Code**

E - Employee/Subscriber
SP - Spouse
C - Child Under Age 26
SC - Stepchild Under Age 26
O - Other (Attach supporting documentatic

## SECTION 3

**Do you, your spouse or dependent(s) maintain other health coverage?** ☐ Y ☐ N **If yes, complete below:**

| Company Name | Company Address (where claims are sent) | Policy Effective Date |
|---|---|---|
| | | |

| Name of Policy Holder | Employer of Policy Holder | Date of Birth of Policy Holder | Dependent(s) Covered Under this Contract |
|---|---|---|---|
| | | | |

Are you, your spouse or any dependents listed in Section 2 enrolled in Medicare? ☐ Y ☐ N If yes, please select reason for Medicare eligibility ☐ End Stage Renal Disease ☐ Disabled ☐ Over Age 65 ☐ Over Age 65 working

## SECTION 4

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize health care professional or entity to give McLaren Health Plan, and any of its designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative or other purpose, including, but not limited to treatment, coordination of care, quality assessment and measurement, accreditation, billing, evaluation of an application or claim, and for any analytical research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification.

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.

| Employee Signature | Date |
|---|---|
| | |

## SECTION 5 — GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES

| Group Name | MHP Group Number | Division | Plan Code | Work Location of Employee |
|---|---|---|---|---|
| | | | | |

| | | | |
|---|---|---|---|
| ☐ Enrollment | Effective Date | Date of Hire | Reason for Enrollment Eligibility ☐ New Hire ☐ Open Enrollment ☐ Other Please Explain: |
| ☐ Change | Effective Date | Select Reason for Change Below and Attach any Supporting Documentation to Substantiate Change ☐ Marriage ☐ Birth/Adoption of Child ☐ Name Change ☐ Address Change ☐ Change to COBRA ☐ Other Please Explain: | |
| ☐ Termination | Date to Terminate Coverage | Terminate (select one) ☐ Contract ☐ Spouse ☐ Dependent(s) | Reason for Termination ☐ Left Employment ☐ Divorce ☐ Dependent Over Age ☐ Other Please Explain: |
| ☐ Medicare Eligibility | Medicare Effective Date | Primary Contract ☐ Medicare ☐ MHP | Group Administrator Signature |