



2025 CHANGE FORM

McLaren Health Plan Community Individual (Off Exchange) Application

HEALTH PLAN COMMUNITY

Mail completed application to: McLaren Health Plan Community, G-3245 Beecher Rd. Flint, MI 48532

Questions? Call: 888-327-0671 Fax: 810-600-7931

APPLICANT INFORMATION – PRIMARY APPLICANT

Applicant Name:				Member ID:	
Street Address:		City:	State:	Zip Code:	County:
Home Phone Number: ()		Work Phone Number: ()		Mobile Phone Number: ()	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					

Are all applicants United States citizens, have a valid social security number, or non-U.S. citizens lawfully present in the U.S. and expected to remain so for the coverage year? Yes No

APPLICANT INFORMATION – LIST ALL INDIVIDUALS APPLYING FOR COVERAGE

Add or Delete	Name (Last, First, MI)	Gender	Race	Ethnicity	Language Preference	Birthdate (mm/dd/yyyy)	SS# <small>(you must supply this unless a child is less than 90 days old or the applicant is a lawful non-citizen)</small>	Primary Care Physician	Tobacco Usage
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Primary Name:								
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Spouse Name:								
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name:								
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name:								
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name:								
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name:								



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PLAN COVERAGE SELECTION

<input type="checkbox"/> MHP Gold \$1,400/\$2,800 Deductible, 20% Coinsurance Total Out of Pocket Max \$8,000/\$16,000	<input type="checkbox"/> MHP Gold Standard \$1,500/\$3,000 Deductible, 25% Coinsurance, Total Out of Pocket Max \$7,800/\$15,600
<input type="checkbox"/> MHP Silver Exchange Rewards \$8,000/\$16,000 Deductible, 50% Coinsurance, Total Out of Pocket Max \$8,250/\$16,500 Reduced deductible of \$2,000/\$4,000 for Rewards providers	<input type="checkbox"/> MHP Silver Standard \$5,000/\$10,000 Deductible, 40% Coinsurance, Total Out of Pocket Max \$8,000/\$16,000
<input type="checkbox"/> MHP Silver Exchange \$3,500/\$7,000 Deductible, 20% Coinsurance Total Out of Pocket Max \$9,200/\$18,400	<input type="checkbox"/> MHP Bronze \$7,500/\$15,000 Deductible, 50% Coinsurance Total Out of Pocket Max \$9,200/\$18,400
<input type="checkbox"/> MHP Bronze Saver (Expanded) \$8,300/\$16,600 Deductible, 0% Coinsurance Total Out of Pocket Max \$8,300/\$16,000	<input type="checkbox"/> MHP Expanded Bronze Standard \$7,500/\$15,000 Deductible, 50% Coinsurance, Total Out of Pocket Max \$9,200/\$18,400
<input type="checkbox"/> MHP Young Adult/Catastrophic (30 years old or younger) \$9,200/\$18,400 Deductible, 0% Coinsurance Total Out of Pocket Max \$9,200/\$18,400	



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PLAN COVERAGE SELECTION (Continued)

Change	Effective Change Date: ____/____/____	Select reason for change below and attach any supporting documentation to substantiate change: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption of Child <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Other-Please Explain: _____	
Termination	Effective Date to Terminate Coverage: ____/____/____	Terminate (select one): <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s)	Reason for Termination: <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent Over Age <input type="checkbox"/> Other-Please Explain: _____
Applicant Signature:		Date:	
Agent's Name:		Date:	

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McLarenHealthPlan.org