



ENROLLMENT/CHANGE FORM
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

Home Phone Number: _____ Area Code: _____ Work Phone Number: _____
 Marital Status: Single Married Divorced Widowed

List All Persons to be Added or Deleted

Circle One	Member Type	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
1	Subscriber				<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N
2	Spouse				<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N
3	Dependent 1				<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N
4	Dependent 2				<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N
5	Dependent 3				<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N

Primary Care Physician Information (REQUIRED FOR EACH ENROLLEE)

Street Address: _____ City: _____ State: _____ Zip Code: _____
 Contract Number: _____ Previous MHP or Health Advantage Affiliation: _____ * Relationship Code: _____
 E - Employee/Subscriber
 SP - Spouse
 C - Child Under Age 26
 SC - Stepchild Under Age 26
 O - Other (Attach supporting documentation)

SECTION 2

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): _____
 Date of Birth of Policy Holder: _____ Date of Birth of Policy Holder: _____
 Employer of Policy Holder: _____ Date of Birth of Policy Holder: _____
 Dependent(s) Covered Under this Contract: _____
 Policy Effective Date: _____

SECTION 3

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
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 4

GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES

Group Name: _____ MHP Group Number: _____ Division: _____ Plan Code: _____ Work Location of Employee: _____

Reason for Enrollment Eligibility: New Hire Open Enrollment Other Please Explain: _____

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: _____

Reason for Termination: Contract Spouse Dependent(s) Left Employment Divorce Dependent Over Age Other Please Explain: _____

Primary Contract: _____ Medicare: MHP