ENROLLMENT/CHANGE FORM

McLaren HEALTH PLAN COMMUNITY

SECTION 1 — SUBSCRIBER INFORMATION - COMPLETE SECTION 1 - 4

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

Street Address ☐ check if new	City	State	Zip Code	County

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