



HEALTH PLAN COMMUNITY

## 2018 CHANGE FORM

### McLaren Individual (Off Exchange) Application

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

Questions? Call: (888) 327-0671 Fax: (810) 733-9596

#### APPLICANT INFORMATION – PRIMARY APPLICANT

<b>Applicant Name:</b>			<b>Member ID:</b>	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>
<b>Home Phone Number:</b> (       )	<b>Work Phone Number:</b> (       )		<b>Mobile Phone Number:</b> (       )	
<b>Marital Status:</b> <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 a non-U.S. citizen 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	Birthdate (mm/dd/yyyy)	SS# (you must supply this unless a child is less than 90 days old or the applicant is a lawful non-citizen)	Primary Care Physician	Tobacco Usage
<input type="checkbox"/> Add	<b>Primary Name:</b>	<input type="checkbox"/> M				<input type="checkbox"/> Y
<input type="checkbox"/> Delete		<input type="checkbox"/> F				<input type="checkbox"/> N
<input type="checkbox"/> Add	<b>Spouse Name:</b>	<input type="checkbox"/> M				<input type="checkbox"/> Y
<input type="checkbox"/> Delete		<input type="checkbox"/> F				<input type="checkbox"/> N
<input type="checkbox"/> Add	<b>Name:</b>	<input type="checkbox"/> M				<input type="checkbox"/> Y
<input type="checkbox"/> Delete	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> F				<input type="checkbox"/> N
<input type="checkbox"/> Add	<b>Name:</b>	<input type="checkbox"/> M				<input type="checkbox"/> Y
<input type="checkbox"/> Delete	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> F				<input type="checkbox"/> N
<input type="checkbox"/> Add	<b>Name:</b>	<input type="checkbox"/> M				<input type="checkbox"/> Y
<input type="checkbox"/> Delete	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> F				<input type="checkbox"/> N
<input type="checkbox"/> Add	<b>Name:</b>	<input type="checkbox"/> M				<input type="checkbox"/> Y
<input type="checkbox"/> Delete	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> F				<input type="checkbox"/> N



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#### PLAN COVERAGE SELECTION

☐ **McLaren Individual Silver Non-Rewards**

\$4,000/\$8,000 Deductible; 30% Coinsurance;  
Total Out-of-pocket Max \$7,350/\$14,700

☐ **McLaren Bronze**

\$5,500/\$11,000 Deductible; 50% Coinsurance;  
Total Out-of-pocket Max \$7,350/\$14,700

☐ **McLaren Gold Standard**

\$1,400/\$2,800 Deductible; 20% Coinsurance;  
Total Out-of-pocket Max \$5,000/\$10,000

☐ **McLaren Silver Standard**

\$3,500/\$7,000 Deductible; 20% Coinsurance;  
Total Out-of-pocket Max \$7,350/\$14,700

☐ **McLaren HSA Bronze 6550**

\$6,550/\$13,100 Deductible;  
Total Out-of-pocket Max \$6,550/\$13,100

☐ **McLaren Young Adult/Catastrophic**

\$7,350/\$14,700 Deductible;  
Total Out-of-pocket Max \$7,350/14,700



**Change**

**Effective Change Date:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Select reason for change below and attach any supporting documentation to substantiate change:**

☐ Marriage

☐ Birth/Adoption of Child

☐ Name Change

☐ Address Change

☐ Other-Please Explain: \_\_\_\_\_



**Termination**

**Effective Date to Terminate Coverage:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Terminate (select one):**

☐ Contract

☐ Spouse

☐ Dependent(s)

**Reason for Termination:**

☐ Divorce

☐ Dependent Over Age

☐ Other-Please Explain: \_\_\_\_\_

**Applicant Signature:**

**Date:**

**Agent's Name:**

**Date:**

G-3245 Beecher Road • Flint, Michigan • 48532

tel (888) 327-0671 • fax (877) 502-1567

[McLarenHealthPlan.org](http://McLarenHealthPlan.org)