McLaren HEALTH PLAN

Individual Census - Off Exchange

For Agent Use Only	
Agent/Agency Name:	
Email Address:	
Phone Number:	
Fax Number:	

Member Name:					
Phone Number:					
Fax Number:					
Email:					
Effective Date Requested:					
Address (all areas below must be complete)					
Street Address:		**City:**		**State:**	**Zip:**

Member's Name		**Date of Birth**		
(Include all names of family under member's name and their date of birth if applicable)				
Last	**First**	**Month**	**Day**	**Year**
Doe *Example*	John	1	11	1971
Doe	John Jr.	1	11	2001

Thank you for inquiring about McLaren Health Plan's Individual Health Plan. Please submit the above form to:

McLaren Health Plan
PO Box 1500
Flint, MI 48501-1500
or you may fax the form to (810) 733-9596

If you have any questions, please call us at (888) 327-0671 and ask to speak to a sales representative.

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