McLaren HEALTH PLAN COMMUNITY

2019 CHANGE FORM

McLaren Health Plan Community 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				
Applicant Name:			**Member ID:**	
Street Address:	**City:**	**State:**	**Zip Code:**	**County:**
Home Phone Number: ( )	**Work Phone Number:** ( )		**Mobile Phone Number:** ( )	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ 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
☐ Add ☐ Delete	**Primary Name:**	☐ M ☐ F				☐ Y ☐ N
☐ Add ☐ Delete	**Spouse Name:**	☐ M ☐ F				☐ Y ☐ N
☐ Add ☐ Delete	**Name:** ☐ Dependent Child	☐ M ☐ F				☐ Y ☐ N
☐ Add ☐ Delete	**Name:** ☐ Dependent Child	☐ M ☐ F				☐ Y ☐ N
☐ Add ☐ Delete	**Name:** ☐ Dependent Child	☐ M ☐ F				☐ Y ☐ N
☐ Add ☐ Delete	**Name:** ☐ Dependent Child	☐ M ☐ F				☐ Y ☐ N

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PLAN COVERAGE SELECTION	
☐ **McLaren Gold 1400** $1,400/$2,800 Deductible, 20% Coinsurance Total Out of Pocket Max $5,000/$10,000	☐ **McLaren Bronze 6500** $6,500/$13,000 Deductible, 50% Coinsurance Total Out of Pocket Max $7,900/$15,800
☐ **McLaren Silver Exchange** $3,700/$7,400 Deductible, 20% Coinsurance Total Out of Pocket Max $7,900/$15,800	☐ **McLaren Bronze HSA 6550** $6,550/$13,100 Deductible, 0% Coinsurance Total Out of Pocket Max $6,550/$13,100
☐ **McLaren Silver 5000** $5,000/$10,000 Deductible, 30% Coinsurance Total Out of Pocket Max $7,900/$15,800	☐ **McLaren Young Adult/Catastrophic** $7,900/$15,800 Deductible, 0% Coinsurance Total Out of Pocket Max $7,900/$15,800

☐ **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