Enrollment Application/Change Form

HealthPlus

Upon completion, please send this document via mail, e-mail or fax to:
ATTN: Enrollment Dept.
HealthPlus of Michigan
Mail: PO Box 1700, Flint, MI 48501-1700
E-mail: hpenroll@healthplus.org
Fax: (810) 733-1925

SECTION 1 – To be completed by employer

Group name	10-Digit Group/Division #	Effective date of coverage

NEW ENROLLEE (Indicate new enrollee in Section 4)

☐ New hire ☐ Rehire ☐ Open enrollment ☐ Other _____ Date of hire/rehire _____

Select health plan: ☐ HMO ☐ POS ☐ PPO Enrollees: ☐ Employee only ☐ Employee/spouse ☐ Employee/child(ren) ☐ Family

ADD SPOUSE OR DEPENDENT (Indicate addition in Section 4)

☐ Add spouse ☐ Add dependent(s) Please select event: ☐ Marriage ☐ Birth, adoption ☐ Other _____ Effective date _____

CHANGE INFORMATION (Indicate change in Section 4)

☐ Address change ☐ Name change New name: _____ ☐ Transfer to COBRA COBRA effective date: _____

CANCEL COVERAGE (Indicate cancellation in Section 4)

☐ Cancel all coverage ☐ Cancel enrollee coverage ☐ Cancel spouse coverage ☐ Cancel dependent(s) coverage

Please select event: ☐ Divorce ☐ Death ☐ Terminated employment ☐ Other _____ Coverage termination date _____

SECTION 2 – Employee information

Last name	First name		M.i.	
Street address	City	State	Zip	County
E-mail address	Home phone		Business phone	
DOB	Social Security #	☐ Male ☐ Female	☐ Single ◯ Married	
Primary care physician	☐ New or ☐ Existing patient		Employee disabled?* ☐ Yes	

SECTION 3 – Language, Race, Ethnicity

What language do you feel most comfortable speaking?	What language do you prefer for written materials?	What is the primary language spoken at home?
☐ English ☐ Non-English: Please indicate language _____ ☐ Decline	☐ English ☐ Non-English: Please indicate language _____ ◯ Decline	☐ English ☐ Non-English: Please indicate language _____ ☐ Decline

Race (Select one or more):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline ☐ Unknown

*Please attach physician certification of disability including date disability developed.

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SECTION 4 – Persons to be covered

PPO members are not required to provide primary care physician information.
Please attach another sheet of paper if you need more room to list dependents.

Spouse's First, MI, Last name	DOB	Social Security #	☐ Male ☐ Female	
Primary care physician	☐ New or ☐ Existing patient		Spouse disabled?* ☐ Yes	
Dependent's First, MI, Last name	DOB	Social Security #	☐ Male ☐ Female	☐ Single ☐ Married
Primary care physician	☐ New or ☐ Existing patient		Dependent disabled?* ☐ Yes	
Home address if different than the one listed in Section 2				
Dependent's First, MI, Last name	DOB	Social Security #	☐ Male ☐ Female	☐ Single ☐ Married
Primary care physician	☐ New or ☐ Existing patient		Dependent disabled?* ☐ Yes	
Home address if different than the one listed in Section 2				
Dependent's First, MI, Last name	DOB	Social Security #	☐ Male ☐ Female	☐ Single ☐ Married
Primary care physician	☐ New or ☐ Existing patient		Dependent disabled?* ☐ Yes	
Home address if different than the one listed in Section 2				
Dependent's First, MI, Last name	DOB	Social Security #	☐ Male ☐ Female	☐ Single ☐ Married
Primary care physician	☐ New or ☐ Existing patient		Dependent disabled?* ☐ Yes	
Home address if different than the one listed in Section 2				

SECTION 5 – Coordination of benefits

For any dependent named in Section 4, is there a court order saying which parent is responsible for providing health insurance?

☐ Yes ☐ Mother ☐ Father Please provide a copy of the court order.

If you, your spouse or your dependents have other health insurance under a group plan or Medicare, please provide the following information:

Name of covered person	Insurance company	Insurance policy #	Name of employer
Medicare ☐ Part A ☐ Part B ☐ Actively working ☐ Retired			
Name of covered person	Insurance company	Insurance policy #	Name of employer
Medicare ☐ Part A ☐ Part B ☐ Actively working ☐ Retired			

SECTION 6 – Acknowledgement

I hereby apply on my behalf and on behalf of the person(s) listed on this application to HealthPlus of Michigan, Inc. or HealthPlus Insurance Company for the coverage now being offered. I understand that this application is subject to acceptance by HealthPlus and that services provided will be subject to the benefits, limitations and exclusions described in my HealthPlus Subscriber Contract or Certificate of Coverage (Contract). I agree to be bound by all terms and conditions of the Contract. I understand that the Contract may be terminated by HealthPlus if I have knowingly given false information on this application. I affirm that the information provided on this application is true, complete and accurate. I understand that I am under no obligation to apply for coverage from HealthPlus. I consent to allow HealthPlus to obtain medical records from providers of service relating to me and any persons listed on this application necessary for the administration of my contract with HealthPlus in accordance with all applicable federal and state laws. If HealthPlus' intent is to release information other than that related to treatment, payment or operations, HealthPlus will require a separate authorization to be signed by the individual(s) whose records are being released prior to release. I give my express consent to allow HealthPlus to contact me at the phone number(s) listed above, including calls made to a cell phone using an automatic telephone dialing system or an artificial or prerecorded voice message system.

Employee/Applicant Signature	Date
Employee Representative Signature	Date

*Please attach physician certification of disability including date disability developed.

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Instructions for Enrollment Change Form
HealthPlus of Michigan, Inc. (HMO or POS)
HealthPlus Insurance Company (PPO)

SECTION 1 – To be completed by employer

1. Complete Group name, Group/Division # and Date of hire/rehire section.
2. Check all the boxes that apply to indicate if this is a new enrollee or if this is a request to change coverage.
3. Indicate the event and event date if applicable.
4. Additions must be reported within 30 days of the date of occurrence.

SECTION 2 – Employee information – To be completed by employee

1. Complete all areas.

SECTION 3 - Language, Race, Ethnicity

1. Complete all areas.

SECTION 4 – Persons to be covered – To be completed by employee

1. Complete all areas that apply. If you are adding a spouse or new dependent or you are cancelling coverage, please indicate the addition or cancellation in this section.
2. PPO members are not required to provide primary care physician information.
3. HMO and POS members should select a primary care physician for each individual covered.
4. Please indicate if the dependent is disabled.
5. Please attach another sheet of paper if you need more room to list dependents.

SECTION 5 – Coordination of benefits – To be completed by employee

1. If applicable, please indicate if there is a court order to provide health insurance for any dependent listed in Section 4.
2. Complete this section if you, your spouse or any dependent have other health care coverage through an employer or Medicare.

SECTION 6 – Acknowledgement

1. Employee signature is required for processing of enrollment application.
2. Employer representative signature is required for processing of enrollment application.

If you have any questions or need assistance with this application, please contact the HealthPlus Enrollment Department at 1-800-345-9956, ext. 2190 or e-mail hpenroll@healthplus.org.