# Member Enrollment/Change Form

McLaren HEALTH PLAN | GROUP INDIVIDUAL MEDICAID MEDICARE

## SECTION A. SUBSCRIBER INFORMATION

| Subscriber Last Name | Subscriber First Name | Middle Initial | |
|---|---|---|---|

| Street Address | City | State | Zip Code | County | Area Code |
|---|---|---|---|---|---|
| | | | | | |

| ☐Work ☐Home | Primary Phone Number | ☐Home ☐Cell | Primary Phone Number | Email | Marital Status ☐Single ☐Married |
|---|---|---|---|---|---|
| | | | | | |

## SECTION B.

**SUBSCRIBER AND DEPENDENTS LIST ALL PERSONS TO BE ADDED OR DELETED.**
If you have five or more dependents, complete additional copies of this form.

**PRIMARY CARE PHYSICIAN (PCP) INFORMATION**
required for each enrollee

| Member Type | Select One | Last Name | First Name | Middle Initial | Gender | Date of Birth MM/DD/YYYY | Race | Ethnicity | Language Preference | Social Security Number/TIN | Relationship Code | Last Name | First Name |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Subscriber | ☐ Add ☐ Delete | | | | | | | | | | | | |
| Spouse | ☐ Add ☐ Delete | | | | | | | | | | | | |
| Dependent 1 | ☐ Add ☐ Delete | | | | | | | | | | | | |
| Dependent 2 | ☐ Add ☐ Delete | | | | | | | | | | | | |
| Dependent 3 | ☐ Add ☐ Delete | | | | | | | | | | | | |
| Dependent 4 | ☐ Add ☐ Delete | | | | | | | | | | | | |

**If the permanent address of the spouse or dependent is different from the subscriber above, please complete the information below:**

| Spouse or Dependent (Full Name) | Street Address | City | State | Zip Code | Dependent(s) Residing at this Address |
|---|---|---|---|---|---|
| | | | | | |

## SECTION C: OTHER HEALTH CARE COVERAGE (COORDINATION OF BENEFITS AND MEDICARE INFO.)

**Do you, your spouse or dependents have other health coverage? ☐ Yes ☐ No If yes, please complete the following:**

| Insurer/Company Name | Insurer/Company Address (where claims are sent) | Policy/Contract Number | Policy Effective Date |
|---|---|---|---|
| | | | |

| Name of Policy Holder | Employer of Policy Holder | Policy Holder's Date of Birth (MM/DD/YYYY) | Dependent(s) Covered Under this Contract |
|---|---|---|---|
| | | | |

**Are you, your spouse or any dependents listed in Section B enrolled in Medicare? ☐ Yes ☐ No If yes, please select reason for Medicare eligibility**

| Reason for Medicare eligibility | Medicare ID | Effective Dates for Medicare Parts A, B, D |
|---|---|---|
| | | |

## SECTION D

**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 E: EMPLOYER/GROUP USE ONLY – CHECK AND COMPLETE APPROPRIATE BOXES

| Group Name | MHP Group Number | Division | Plan Code |
|---|---|---|---|
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|---|---|---|---|
| ☐ **Enrollment** | Effective Date | Date of Hire | Reason for Enrollment Eligibility |
| ☐ **Change** | Effective Date | Select reason for change below and attach any supporting documentation to substantiate change. | |
| ☐ **Termination** | Date to Terminate Coverage | Terminate (select one) | Reason for Termination |
| ☐ **Medicare Eligibility** | Medicare Effective Date | Group Administrator Signature | |