Changes apply to:
- ☐ Medical Only
- ☐ Dental Only
- ☐ Medical and Dental

MEDICAL & DENTAL CHANGE FORM

PLEASE PRINT

Social Security #	Medical Member #	Dental Member #
Employee Name	Employer Name	Employee Division

NAME OR ADDRESS CHANGES

Name		Telephone #
Address		City
State	Zip Code	Email Address

REASON & EFFECTIVE DATE OF CHANGE

Employee Coverage End Date____________________ Reason ____________________

Employee/Spouse/Dependent Change ☐ Marriage ☐ Birth ☐ Adoption ☐ Divorce ☐ Death ☐ Other_______________

Comments:

Please attach documentation such as court documents, Certificate of Creditable Coverage, etc.

List eligible Dependents to be covered/terminated, oldest to youngest. A Dependent is a person who is: 1) the Subscriber's legal spouse; 2) a child of the Subscriber who is a son, daughter or step-child or a child subject to legal guardianship regardless of support level; 3) a grandchild or other blood relative of the Subscriber who depends on the Subscriber for more than 50% of total support; 4) a child of the Subscriber who is recognized under a QMCSO as having a right to enroll under the Contract. List last name if different from employee.

Dependent Name ____________________ Relationship ____________________

Social Security #____________________ Date of Birth ____________________ Gender: MALE FEMALE

Dependent Address____________________

Medical: ☐ Add ☐ Delete Effective Date____________________ **Dental:** ☐ Add ☐ Delete Effective Date____________________

Dependent Name ____________________ Relationship ____________________

Social Security #____________________ Date of Birth ____________________ Gender: MALE FEMALE

Dependent Address____________________

Medical: ☐ Add ☐ Delete Effective Date____________________ **Dental:** ☐ Add ☐ Delete Effective Date____________________

Dependent Name ____________________ Relationship ____________________

Social Security #____________________ Date of Birth ____________________ Gender: MALE FEMALE

Dependent Address____________________

Medical: ☐ Add ☐ Delete Effective Date____________________ **Dental:** ☐ Add ☐ Delete Effective Date____________________

COORDINATION OF BENEFITS INFORMATION: Have you ever been a PHP member? ☐ Y ☐ N

On the date that Coverage is to be effective, will you or your Dependent(s) have any other Coverage? ☐ Y ☐ N If yes, complete the following:

Health Plan Name____________________ Policy/Group/ID #____________________

Dental Plan Name____________________ Policy/Group/ID #____________________

Claims Address/Phone #____________________ Effective Date____________________ Termination Date____________________

Policyholder's Name____________________ Policyholder's Social Security #____________________

Covered Individuals____________________ Policyholder's Birth Date____________________

Employer through which coverage is held____________________ ☐ Medicare Plan A (Hospital only) ☐ A & B (Hospital & Medical)

I (WE) HEREBY REPRESENT that all statements and answers herein are full, complete and true. These statements and answers are to be considered as the basis for Coverage under the Plan. I understand that (1) this form constitutes a part of the Plan Contract and (2) no Coverage will be effective until the date specified by the Plan.

EMPLOYEE SIGNATURE:____________________ Date:____________________

EMPLOYER SIGNATURE:____________________ Date:____________________

Physicians Health Plan of Northern Indiana, Inc. ***PHP Insurance Company of Indiana, Inc.***

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