Change of Status Form

Thank you for choosing the MDA Health Plan. Please complete this form for yourself and any dependents who require a change. A few reminders to help you complete this form:

- Qualifying events for mid-year changes are outlined in the Summary Plan Document. Changes must be submitted within 30 days of the qualifying event and documentation must be provided.
- If you have any questions or need assistance while completing this form, please call 1-877-906-9924 and press 9.
- Mail completed form to MDA Insurance, 3657 Okemos Road, Suite 100, Okemos MI 48864 OR FAX to 517-484-5460.

Employee Information

Employee Name *(last, first, initial)*	**Email Address**	**Primary Phone Number**	**Secondary Phone Number**

Date of Birth *(month/day/year)*	**Gender**	**Marital Status** ☐Single ☐Married ☐Widowed ☐Divorced	**Social Security Number**

Home Street Address ☐Indicate New Address	**City**	**State**	**ZIP**

Medical Plan Selection

☐ Simply Copays (0) ☐ Premier Elite PPO (1) ☐ Elite PPO (2) ☐ Select PPO (3) ☐ Classic Plus PPO (4) ☐ Elite HSA (5)
☐ Family Focus HSA (6) ☐ Family Focus PPO (8) ☐ Advanced Value Plan (10) ☐ Living Fit PPO (11) ☐ Living Fit HSA (12)

Employee Signature	**Today's Date**

List All Persons to be Added or Deleted

Dependent 1

☐Enroll ☐Change ☐Terminate Date of Change:

Dependent Name *(last, first, initial)*	**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____		
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*	**City**	**State**	**ZIP Code**

Dependent 2

☐Enroll ☐Change ☐Terminate Date of Change:

Dependent Name *(last, first, initial)*	**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____		
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*	**City**	**State**	**ZIP Code**

Dependent 3

☐Enroll ☐Change ☐Terminate Date of Change:

Dependent Name *(last, first, initial)*	**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____		
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*	**City**	**State**	**ZIP Code**

Coordination of Benefits Information

Do you, your spouse, or your dependents maintain other coverage? ☐Yes ☐No If yes, complete below. ☐Check here if this applies to all members on the contract.

Person Covered *(last, first, initial)*	**Employer or Group Name**	**Carrier**

Address	**Subscriber Signature**

Employer Information (to be completed by employer)

Company Name	**EIN**	**Company Phone**	**Company Email Address**

Company Street Address	**City**	**State**	**ZIP Code**

Date of Event	**Effective Date**

Check Reason for Change	**Check Type of Cancellation**	**Check Reason for Cancellation**
☐Marriage ☐Name Change ☐Dependents ☐Address Change ☐Loss of Coverage ☐Open Enrollment	☐Subscriber ☐Spouse ☐Dependent	☐COBRA ☐Death ☐Left Employment ☐Divorce ☐Dependent Over Age ☐Other ☐Retirement ☐Other Insurance Last Date of Coverage _____

Loss of Eligibility (prior coverage) ☐Yes ☐No	**If yes, Carrier Name**	**Policy Holder Name**	**Policy Number**	**Termination Date**

Are any members listed enrolled in Medicare? ☐Yes ☐No	**If yes, Reason** ☐Working Aged ☐Disabled ☐ESRD	**HIC Number**

☐Medicare Primary ☐MDA Health Plan Primary	**Medicare A Effective Date**	**Medicare B Effective Date**	**Medicare D Effective Date**

Employer Signature	**Today's Date**