HealthChoice of Michigan
500 Griswold, 15th Floor
Detroit, MI 48226

Subscriber Application Form

PRINT CLEARLY

GROUP #_____

First Name:	Last Name:	Jr., Sr., I, II, etc	Phone Number ( )	**Circle One** New Change Term
Social Security #	Date of Birth	Sex	**DATE OF HIRE**	
Home Address:	City	County	State	Zip Code
Do you have other medical insurance coverage? Yes or No	If Yes, Insurance Name:	Policy #	Date when coverage ending	
Email address:				

List the names of each eligible dependents to be covered (see reverse side for dependent criteria)

1	First Name:		Last Name:		Jr., Sr., I, II, etc	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? Yes ◯ No ◯	If yes, insurance Name:	
2	First Name:		Last Name:		Jr., Sr., I, II, etc	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? Yes ◯ No ◯	If yes, insurance Name:	
3	First Name:		Last Name:		Jr., Sr., I, II, etc	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? Yes ◯ No ◯	If yes, insurance Name:	

Dependent change only: Date of event: _____Circle One: Marriage Newborn Principle Support Adoption/Legal Guardianship

Deletion (Date of event) _____
Circle one: Divorce Death Other _____

By signing below, I acknowledge that I have been provided with at copy of this form, read understand and agree to the conditions listed and attached my most recent pay stub.

Applicant's Signature_____ **Date**_____

Company Name:		
Address:	City	Zip Code
Phone: ( ) -		
Federal Tax Id:		

The undersigned represents and warrants that he/she has been authorized to execute this subscriber application and make the foregoing certifications on behalf of the employer, has been provided a copy and has read, understands and agrees to the conditions on the reverse side of this form.

Employer's Signature_____ **Date**_____

Subscriber ID# _____

Effective Date: _____

Phone: 1-800-935-5669 | Fax: 313-967-6386 **Email:** healthchoice@waynecounty.com

SUBSCRIBER CERTIFICATION OF ELIGILIBITY

By submission of this Subscriber Application, I am applying for Basic Services specified in my Subscriber Certificate of Eligibility with HealthChoice of Michigan and any amendments thereto (hereinafter collectively referred to as 'Subscriber Certificate') and for the selected Supplemental Services (also known as 'riders'), as defined in my Subscriber Certificate of Eligibility with HealthChoice of Michigan.

I understand that all Supplemental Services elected have been elected for me and all eligible dependents as defined in the Subscriber Certificate, and that I am responsible for paying my portion, an amount agreed upon with my employer, of the premium for the Supplemental Services in addition to the premium for Basic Services.

By submission of the Subscriber Application, I hereby certify that, to the best of my knowledge, I qualify as a Subscriber under the terms of the Subscriber Certificate by meeting all the following criteria:

A. I am an employee of a qualified employer or a member of a qualified association and have an anticipated work future of more than five (5) months.

B. I am currently without health care benefits and am not eligible, without regard to the availability of coverage, for Medicare, Medicaid or other employer sponsored health coverage.

C. I am currently working at least 20 hours per week. I agree to notify HealthChoice if my hours are reduced to less than 20 hours per week for any reason at any time after enrollment.

D. My employer has not offered or contributed to health care benefits of employees in the same or similar job classification in which I am employed in the 65-day period immediately preceding the effective date of the Group Operating Agreement between my employer and HealthChoice of Michigan.

E. I am a resident of the State of Michigan as defined in the Subscriber Certificate, and I have accurately listed the County of my residence.

F. I have completed and signed this Subscriber Application for enrollment.

By submission of this Subscriber application for an eligible dependent as defined in the Subscriber Certificate, I hereby certify that, to the best of my knowledge, each eligible dependent listed on this application qualifies as an eligible dependent under the terms of the Subscriber Certificate by meeting all of the following criteria:

A. Be my spouse (Family income is not exceeded), OR

B. Be a child of the Subscriber, which is defined as a son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Subscriber until the child reaches the age of 26. An eligible foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adopted child includes both a legally adopted child of the Subscriber and a child who is lawfully placed with the Subscriber for legal adoption by the Subscriber.

C. Not serving in the United States Armed Forces.

D. Be without health care benefits and not be eligible for any other health care program at time of enrollment.

By submission of this subscriber Application to my employer, I hereby authorize my employer to deduct from my wages, as a payroll deduction, an amount not to exceed that portion of the monthly advance premium and any Supplemental Services selected for myself and eligible dependents that my employer may charge to me under the terms of the subscriber Certificate of Eligibility.

I understand that the Member Handbook/Subscriber Certificate, any riders thereto and this Subscriber Application Form contain the specific provisions and limitations of my coverage and are my contract with HealthChoice of Michigan.

I further certify that I have available to me the Member Handbook/Subscriber Certificate and I acknowledge its' availability online at https://healthchoiceofmichigan.com/handbook.pdf

I appoint my employer as my agent to handle all matters of HealthChoice of Michigan coverage.

I am responsible for giving notices of changes in my status and that of my family members, which affect coverage, to my employer. I authorize HealthChoice of Michigan to obtain hospital and medical records relating to me and my family from providers of service. HealthChoice or its Managed Care Providers may require any person to verify their ineligibility for Medicaid or Medicare by completion and submission of an application for Medicaid or Medicare benefits as a part of the Subscriber Application for the person or at any time during the period a person is a member. Refusal by a Member of request by the Program or its Managed Care Providers to complete and apply for Medicaid or Medicare benefits may result in termination of this Subscriber Certificate for the Member.

I represent and warrant that the information provided by me on this Subscriber Application is true, correct, and complete.

I understand that if I falsify or withhold information requested by HealthChoice on the Subscriber Application, or as required under the Subscriber Certificate, including a refusal of a request by HealthChoice or its Managed Care Providers, I will be terminated from the Program immediately and coverage for myself and my eligible dependents will end as of the effective date of termination.

EMPLOYER CERTIFICATION

By execution of and submission of this Subscriber Application, the undersigned certifies, on behalf of the employer, that to the best of the employer's knowledge, the applicant qualifies as a Subscriber under the terms of the Subscriber Certificate, that all eligible dependents for whom coverage is sought by the Subscriber qualify as eligible dependents under the terms of the Subscriber Certificate and that the employer qualifies as a Group whose employees may enroll as Subscribers under the terms of the Subscriber Certificate by meeting the following criteria unless waived in writing by HealthChoice.

A. Have their principal place of business for global operations located in Wayne or Oakland County.

B. At the time the Group enters into the Group Operating Agreement, the Group has two (2) or more employees that work full-time (30 hours or more weekly) who are otherwise eligible to enroll as Subscribers.

C. Including this Subscriber Application, the employer has submitted two (2) or more complete Subscriber Application for employees who otherwise qualify as Subscribers and will have two (2) or more employees enrolled in the program.

D. That 75% of full-time eligible employees are participating in the Plan.

E. At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.

F. The employer has entered into a Group Operating Agreement with HealthChoice of Michigan.

G. Has provided verification of the legal existence of their business and list of employees.

If this form is being submitted for purposes of a Subscriber Change Form relating to COBRA coverage, employer certifies that it is responsible for determining the employee's eligibility for COBRA coverage and sending out all required COBRA notifications. Employer agrees to indemnify and hold harmless HealthChoice of Michigan related to COBRA eligibility, notification, and coverage.