MHIP

Maryland Health Insurance Plan

Attn: MHIP Enrollment, c/o Plan Administrator
10800 Red Run Blvd., RR-380
Owings Mills, MD 21117
Fax: 410-505-2909

ENROLLMENT COVERAGE CHANGE FORM

(Please fill out this form **only** if you are changing plan and demographic information)

SECTION 1: SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex: ☐Male ☐Female	Date of Birth: / /	Member ID Number:	Marital Status: ☐Single ☐Married	Daytime Phone: ( ) –
Home Address	City		State	Zip Code		Social Security Number	Evening Phone: ( ) –
Mailing Address	City		State	Zip Code			Cellular Phone: ( ) –

SECTION 2: WHO SHOULD BE COVERED

☐ Subscriber Only
☐ Subscriber/Spouse
☐ Subscriber/Child(ren)
☐ Family

SECTION 3: TYPE OF COVERAGE

☐ Change Plan*
☐ Terminate All Coverage
☐ Terminate Spouse/Child

*Must complete Section 4

☐ Add Spouse/Child
☐ Address and/or Name Change

SECTION 4: PLAN SELECTION

☐ HMO Network Plan
☐ $500 PPO Plan
☐ $1,000 PPO Plan
☐ High Deductible Plan
☐ HealthyBlue

SECTION 5: COVERAGE INFORMATION

(A) Add (T) Term (C) Change	Last Name	First Name	M.I.	Zip Code	Date of Birth	Sex	Social Security Number	PCP Name (HMO and HealthyBlue only)	Established Patient?	Other Health Plan Coverage?
	Subscriber								☐ Yes ☐ No	☐ Yes ☐ No
	Spouse								☐ Yes ☐ No	☐ Yes ☐ No
	Child 1								☐ Yes ☐ No	☐ Yes ☐ No
	Child 2								☐ Yes ☐ No	☐ Yes ☐ No
	Child 3								☐ Yes ☐ No	☐ Yes ☐ No

SECTION 6: OTHER INSURANCE

Do you, your spouse or any of your dependents have health coverage under any other health plan including Medicaid or Medicare? ☐ Yes ☐ No
If you answered yes, please complete the information below:

Person's Name with Other Health Plan	Social Security Number
Date of Birth	Sex
Other Company's Policy Number and Effective Date	
Medicare Number	Part A Effective Date:
	Part B Effective Date:

By signing below, I certify that the above information is true and correct. I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance agency, or other person or firm to provide the Plan Administrator (CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.) and any subcontractors, information, including copies of records, concerning advice, care or treatment provided the patient above including but not limited to information relating to mental illness, use of drugs or alcohol, upon presentation of a photocopy of the signed authorization. I understand that such information will be used for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above.

AUTHORIZATION TO RELEASE INFORMATION

I authorize any insurance company, employer, organization, or provider of services to release medical information to Plan Administrator (CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.) and all subcontractors before or after payment.

SUBSCRIBER'S SIGNATURE DATE