Reinstatement Request Form

Return this Form to: MPIPHP • P.O. Box 1999• Studio City, CA 91614-0999

Use this form to request a reinstatement of Active Health Plan coverage for yourself and/or your dependents. Complete and return the signed form to the address indicated above with your payment by check or money order **for the remainder of your eligibility period.** This form must be signed by you, the Participant.

If you are enrolled in an HMO plan (Kaiser, Health Net or Oxford) and 90 days or more have elapsed since you and/or your dependent(s) were last eligible an additional form is required to reinstate your coverage with that HMO plan. Please contact MPI to obtain the necessary form.

Participant Name: ______________________________ **MPID:** ____________________

Payment Enclosed: $ ____________________ **Phone:** (   ) ____________________

List All Dependents to Reinstate (Include Spouses if applicable): ______________________________

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Reason (optional): ____

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I understand that my Active Health Plan coverage will be reinstated the date my payment AND this request **is received by MPI**. My coverage will not be retroactive. I understand that I will not be permitted to request another reinstatement of coverage for three (3) years from the date this document is received by MPI.

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Participant's Signature **Date**

PLEASE ALLOW FIVE (5) BUSINESS DAYS FOR PROCESSING

FOR OFFICE USE ONLY

Request Received Date Stamp

Reinstatement Date: ____________________

Payment Receipt Date: ____________________

Payment Amount: ____________________

Premium Dept. Approval: ____________________
(initials/date)

Reinstatement Completed: ____________________
(initials/date)

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