

MICHIGAN CIVIL SERVICE COMMISSION
EMPLOYEE BENEFITS DIVISION
 400 South Pine Street, P.O. Box 30002
 Lansing, Michigan 48909

APPLICATION FOR CONTINUATION OF INSURANCES

INSTRUCTIONS: Section III of this application **must be completed** by the "APPLICANT" and returned directly to the address above **as soon as possible, whether or not** you wish to enroll. If you do not return this form within 60 days of your loss of coverage due to your qualifying event or within 60 days of the date of this notice (whichever is later), you will **lose your right** to continue coverage as provided by P.L. 99-272, applicable Civil Service Policies and State bargaining contracts. Some of the information on this application is protected by Federal privacy laws and/or State confidentiality requirements.

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|------------------------------|---|------------------|
| Date Application Sent | Section I and II Human Resource Preparer's name and phone number | Return by |
|------------------------------|---|------------------|

SECTION I – TO BE COMPLETED BY PERSONNEL OFFICE

| | | | | | | |
|---|---|--|---|---|---|---|
| Employee I.D. # of Qualified Applicant | | Name of Qualified Applicant (last, first, middle initial) | | | | |
| Applicant's Address | | City | State | Zip Code | Daytime Phone # | |
| Name of Employee/Retiree | | SS # of Employee/Retiree XXX-XX- | Dept./Agency | Unit Code | Was 2 Pay Period Prepay Used for Layoff? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Qualifying Event (QE) Date | Ins. End Date | FMLA Dental/Vision Ins. End Date | | FMLA Adj. Processed <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Qualifying Event (X box that applies) <input type="checkbox"/> 01 Layoff <input type="checkbox"/> 02 Leave of Absence/Suspension | | LTD Rider Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Rider End Date | | Eligible for Waiver of Life Premium? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C O B R A | <input type="checkbox"/> 03 Divorce | | LTD Date Greater Than 12 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No | Health Code | Dental Code | Vision Code |
| | <input type="checkbox"/> 04 Death of Employee | | Elig. Begin Date: | H | D | V |
| | <input type="checkbox"/> 05 Child Ineligible | | | L | | |
| <input type="checkbox"/> 07 Reduction of Hours | | <input type="checkbox"/> Retiree Group | | Medicare Eligibility <input type="checkbox"/> Applicant and/or <input type="checkbox"/> Spouse | | |
| <input type="checkbox"/> 08 Separation from Employment | | | | | | |
| <input type="checkbox"/> 09 Retirement | | | | | | |
| <input type="checkbox"/> 10 Separation from Spouse | | | | | | |

SECTION II – TO BE COMPLETED BY PERSONNEL OFFICE

The applicant may continue any or all of the coverages marked below

| | |
|--|--|
| Applicant <input type="checkbox"/> Health/HMO <input type="checkbox"/> Dental <input type="checkbox"/> Vision | Life (Available only if applicant is employee on layoff or leave of absence) Mark one box. |
| Spouse <input type="checkbox"/> Health/HMO <input type="checkbox"/> Dental <input type="checkbox"/> Vision | <input type="checkbox"/> Emp. \$ _____ <input type="checkbox"/> G (E+\$5,000S \$2,500/C) <input type="checkbox"/> K (E+\$25,000S \$10,000/C) |
| Child(ren) <input type="checkbox"/> Health/HMO <input type="checkbox"/> Dental <input type="checkbox"/> Vision | <input type="checkbox"/> F (E+\$1,500S \$1,000/C) <input type="checkbox"/> H (E+\$10,000S \$5,000/C) <input type="checkbox"/> L (E+\$10,000/C) |

Current Health/HMO Carrier

The applicant **may** continue Health/HMO coverage for 18 months 36 months Duration of leave Other

The applicant **may** continue Dental and/or Vision coverage for 18 months 36 months Duration of leave Other

SECTION III – TO BE COMPLETED BY APPLICANT – Do not write in shaded areas.

APPLICANT: Please fill out completely for yourself and your eligible dependents (who were covered immediately prior to your insurance ending date above). Mark the box(es) for the insurance(s) you wish to continue. You may continue only the insurances marked X in Section II above. **If you are eligible for LTD Rider benefits and need Health/HMO coverage, you must mark the Health/HMO box.** You may choose not to continue one or more insurances and/or not to enroll all or some of your eligible dependents. **Please complete and mail this form even if you do not wish to enroll. Make and retain a copy of this form for your records and mail to address above.**

| Name(s) | Birthday(s) | R E L | | Relationship to Employee/Retiree | Health/ HMO | Dental | Vision | Life (X only one, see Section II) <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> K <input type="checkbox"/> L App. ret. |
|-----------|-------------|-------------|--|----------------------------------|----------------|--------|--------|---|
| Applicant | | | | | | | | |
| Spouse | | | | | | | | |
| Children | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

I have read and agree to the applicable terms and conditions of this application (attached sheet) and I understand that I am forfeiting my rights to future eligibility if I do not enroll for at least one of my previous insurance coverages within my designated 60 day enrollment period.

I wish to enroll as noted in Section III. I do not wish to enroll.

| | |
|------------------------------|-------------|
| Applicant's Signature | Date |
|------------------------------|-------------|

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IMPORTANT: TERMS AND CONDITIONS FOR CONTINUATION OF YOUR INSURANCES

It is in your best interest to accurately complete and sign this application form immediately, so that the Employee Benefits Division can verify the continuation of your requested insurances. **You should return this form even if you do not wish to enroll in any of the insurances.** Mail the completed application to the above address within 7 days, especially if you anticipate filing a claim within the month. Waiting will cause a delay in the notification to those Insurance Plan administrators/carriers responsible for processing and paying your insurance claims. If the form is not received by the Employee Benefits Division by the due date in the upper right hand corner of the form, you will **NOT** be eligible for continuation of your insurances. Make and retain a copy of the form before mailing.

If you are eligible for LTD benefits, and you need continuing Health/HMO coverage, you must return this form requesting the Health/HMO coverage. This will activate your LTD Rider to pay your premium, for up to six months, as long as you are receiving LTD benefits. Dental and Vision premiums are **NOT** paid by the LTD Rider. If your spouse is a state employee or retiree, you may transfer your health, dental, and vision coverage to your spouse, even after using the LTD Rider benefit.

If you are on an approved FMLA leave, the state continues paying its share of the health, dental, and vision premiums for the duration of your FMLA eligibility. You must pay your share of the health and dental premiums. Contact your Human Resource Office for FMLA eligibility information.

Upon receipt of your application, the Employee Benefits Division will send you monthly billing invoices for the coverage(s) you select. If you do not receive your billing invoice or an acknowledgement letter from Employee Benefits Division within 30 days after you submit the form, please call (517) 373-7977 or 1-800-505-5011 to confirm that your form was received.

Continuation of your insurance benefits will depend on your timely, whole (not partial) premium payment by the due date shown on the billing invoice. Please allow seven days for mailing and processing of your payment. Checks returned "Non-Sufficient Funds" (NSF) will cause the termination of your insurance benefits.

You must provide notice, within 31 days, to the Employee Benefits Division of any changes in your status or those of your family members which may affect eligibility and/or billing direction.

Any falsification of these records may result in the cancellation of your insurance benefits.

The benefits you receive will be commensurate with active state employee/retirees. The Employee Benefits Division may cancel your coverage for any of the following reasons:

1. The State of Michigan no longer provides group health insurance coverage to any of its employees/retirees;
2. The premium for continuation coverage is not paid;
3. You become covered under another group health plan;
4. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

If you are in current paid-to-date status and have signed up for and have continued your Health, HMO, Dental, and/or Vision coverage, you may be eligible to participate in a State open-enrollment process.

DEPENDENT ELIGIBILITY

Your spouse and child(ren) may be covered under the State-sponsored Health, HMO, Dental, and Vision plans as long as the dependent(s) meets the following eligibility criteria:

SPOUSE

Your legal husband or wife may be covered as a "dependent" as long as the spouse is not also separately enrolled at the same time as an eligible State Employee or Retiree or under their own COBRA/CGIS coverage with the State.

CHILDREN

Your children by birth, legal adoption or legal guardianship who are in your custody and dependent on you for support. You'll need to provide proof of dependency.

Your children by birth or legal adoption or legal guardianship who do **not** reside with you, but are your legal responsibility for the provision of medical care (for example children of divorced parents).

ENROLLING ELIGIBLE DEPENDENTS

If you acquire any dependents after you are enrolled, you may enroll them within 31 days of the date they were newly acquired (date of marriage, birth, adoption, new residency in the home, etc.). Contact your Personnel Office or Civil Service Employee Benefits for forms.

No person (spouse or child) will be considered a "dependent" while that person is serving in the armed forces of any country. In addition, no person may be covered both as a COBRA "Enrollee" and as a "dependent," and no person may be covered as a "dependent" of more than one enrolled Employee or Retiree. Employees or Retirees or COBRA Enrollees who are married to each other may carry insurance coverages separately, but not with the same dependent children under both coverages.

This material is available in alternative formats, upon request. For further information, call: Voice: (517) 373-7977 or toll free at 1-800-505-5011, Michigan Relay Service: 1-800-649-3777.