

EMPLOYEE BENEFITS DIVISION
APPLICATION FOR CONTINUATION OF INSURANCES

INSTRUCTIONS: This application **must be completed** by the "APPLICANT" and returned directly to the DMB-OSE EBD, P.O. Box 30026, Lansing, MI 48909 **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.

Date Application Sent: / /	Section I and II Human Resource Preparer's name and phone number:	This form must be returned by: / /
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SECTION I - TO BE COMPLETED BY PERSONNEL OFFICE

Social Security Number of Qualified Applicant: - -	Name of Qualified Applicant (last, first, middle initial):	FMLA: <input type="checkbox"/> Yes <input type="checkbox"/> No	Net Pay Adj: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Applicant's Address:	City:	State:	Zip Code: -	Daytime Phone #: - -	
Name of Employee/Retiree	SS # of Employee/Retiree: - -	Dept./ Agency:	Unit Code:	Separation Code:	
Qualifying Event (QE) (X box that applies) <input type="checkbox"/> 01 Layoff <input type="checkbox"/> 02 Leave of Absence/Suspension <input type="checkbox"/> 03 Divorce C <input type="checkbox"/> 04 Death of Employee O <input type="checkbox"/> 05 Child Ineligible B <input type="checkbox"/> 07 Reduction of Hours R <input type="checkbox"/> 08 Separation from Employment A <input type="checkbox"/> 09 Retirement <input type="checkbox"/> 10 Separation from Spouse	QE Date: / /	Ins. End Date: / /	Was 2 Pay Period Prepay Used for Layoff? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	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	Waiver End Date:	
	Original LTD Effective Date: / /	Health Code:	Dental Code:	Vision Code:	Life Code:
	Elig. Begin Date:	H	D	V	L
	CGIS Begin Date:				
	Eligibility End Date:				
	<input type="checkbox"/> Retiree Group	Medicare Eligibility: <input type="checkbox"/> Applicant and/or <input type="checkbox"/> 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)	Social Security Number(s)	Birthday(s)	R	E	L	C	B	Relationship to Employee/Retiree	Health/HMO	Dental	Vision	Life (X only one)
Applicant:												<input type="checkbox"/> E <input type="checkbox"/> F
Spouse:												<input type="checkbox"/> G <input type="checkbox"/> H
Children:												<input type="checkbox"/> K <input type="checkbox"/> L
												App. ret. Proc.by:

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 quickly 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.** Try to mail the completed application to the above address within 7 days, especially if you anticipate filing a claim within the month. If you wait, there will be 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 DMB/OSE 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 you mail it.

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 as long as you are receiving LTD benefits, for up to six months. 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. Health coverages will **NOT** be transferred to your spouse at the end of the LTD Rider period.

Upon receipt of your application, the DMB/OSE Employee Benefits Division will bill you in advance, on a monthly basis, for the coverage(s) you select. If you do not receive a billing or an acknowledgment letter from DMB/OSE Employee Benefits Division within 30 days after you submit the form, please call (517) 373-7977 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. 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 timely notice (within 31 days) to the DMB/OSE 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 employees/retirees. The DMB/OSE 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.

You will be eligible to participate in a State open-enrollment process only if you are a former employee (separated/retired) or a former spouse/child, and you have signed up for and have continued your Health, HMO Dental, and/or Vision coverage.

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 unmarried natural or adopted child who is under age 19 may be covered as a "dependent." This child may also be covered as a "dependent" up to age 25 if s/he is regularly attending school and depending solely on you for support. Any other unmarried child under age 19 may be covered as a "dependent" as long as this child (stepchild, grandchild, niece, nephew, etc.) depends upon you for support and lives with you in a "parent-child" relationship. This child may also be covered as a "dependent" up to age 25 if s/he is regularly attending school and if s/he is depending on you for support.

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 DMB/OSE 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/CGIS "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/CGIS 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, TTY: (517) 335-0191.