

State of Michigan  
Department of Management and Budget  
**OFFICE OF THE STATE EMPLOYER**  
**ENROLLMENT APPLICATION**  
**Health, Dental, Vision, Life and LTD**  
**Plans**

A portion of this information is protected by federal and privacy laws and/or state confidentiality requirements.

*Please type or print FIRMLY with ballpoint pen.*

- New Enrollment  Reinstatement
- Record Change (Check one below)
- Marriage  Birth  Divorce  Death  Ineligible Dependent
- Other (Explain below)

Reason if Other \_\_\_\_\_ Date of Event \_\_\_\_\_

**SECTION A – APPLICANT DATA**

EMPLOYEE ID NO.	EMPLOYEE LAST NAME	FIRST	MI	EMPLOYEE SPOUSE
				ARE YOU OR YOUR SPOUSE ENROLLED IN MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO

**SECTION B – COVERAGE DATA**

HEALTH:	<input type="checkbox"/> State Health Plan	<input type="checkbox"/> HMO	<input type="checkbox"/> Catastrophic Plan	<input type="checkbox"/> Opt Out	<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family
DENTAL:	<input type="checkbox"/> State Dental Plan	<input type="checkbox"/> DMO	<input type="checkbox"/> Preventive Dental Plan		<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family
VISION:	<input type="checkbox"/> State Vision Plan				<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family
LIFE:	<input type="checkbox"/> Reduced Life (One times annual salary to a maximum of \$50,000)  <input type="checkbox"/> Regular Life Two times annual salary to a maximum of \$200,000*  *This life insurance limit may not be applicable to employees who are covered by a collective bargaining agreement.				<input type="checkbox"/> Dependent Life Coverage <input type="checkbox"/> F - Spouse \$1,500 and/or Child(ren) \$1,000 <input type="checkbox"/> G - Spouse \$5,000 and/or Child(ren) \$2,500 <input type="checkbox"/> H - Spouse \$10,000 and/or Child(ren) \$5,000 <input type="checkbox"/> K - Spouse \$25,000 and/or Child(ren) \$10,000 <input type="checkbox"/> L - Child(ren) \$10,000				
LTD:	<input type="checkbox"/> ELECT COVERAGE		<input type="checkbox"/> DECLINE COVERAGE		I have read and understand the conditions under which long term disability benefits can be paid.				
IF HMO, PROVIDE NAME OF HMO & CODE FROM NEW HIRE BENEFIT ELECTION FORM						IF DMO, PROVIDE DENTAL CENTER FROM BACK OF FORM			

**SECTION C – DEPENDENT ENROLLMENT DATA (Attach additional pages if necessary.)**

A D D	D E L	NAME, LAST	FIRST	MI	SOCIAL SECURITY NUMBER	RELATION TO YOU	SEX M/F	DATE OF BIRTH			COVERAGE (Y/N)			
								MM	DD	YYYY	HEALTH	DENTAL	VISION	
		SPOUSE												
		DEPENDENT												
		DEPENDENT												
		DEPENDENT												
		DEPENDENT												
		DEPENDENT												

I have read and agree to the applicable terms and conditions stated on the reverse side of this application. | Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

IF THIS IS AN APPLICATION FOR COVERAGE:

- I certify that the information provided on the front of this form is correct to the best of my information, knowledge, and belief.
- I elect to enroll in the state-sponsored Health, Dental, Vision, Life and/or LTD Plan(s) for which I am eligible, as checked on the front of this application. I understand that this application authorizes the State of Michigan to withhold the contribution(s) required for my enrollment(s).
- I understand that I may enroll my legal spouse and unmarried children under age 19 (or 25 if regularly attending school), who are my own or legally adopted, plus any other unmarried child meeting the age restrictions who depends upon me for support and lives with me in a regular parent/child relationship.
- I also understand that dependent children who are fully handicapped, unable to earn a living because of mental or physical disabilities and depend chiefly on me for support and maintenance may continue to be covered beyond the maximum age provided coverage does not terminate for any other reason and the child is certified as eligible by the Office of the State Employer, Employee Benefits Division.
- I agree to give notice of any changes in my status and status of my family members that affect eligibility. If I acquire a new eligible dependent, plan enrollment must be made either within 31 days of this event or during an open enrollment period.
- I understand that no one may be insured as both an employee/retiree AND as a dependent under these state-sponsored plans; nor may two employees/retirees independently insure the same dependent(s) under state-sponsored plans.
- I authorize the Plan Administrator to obtain from providers of service any and all records and information relating to me and my family members. I understand that this information may also be reviewed by the State of Michigan.

IF I HAVE DECLINED COVERAGE ON THE FRONT OF THIS FORM:

- I understand that I have been offered enrollment in the state-sponsored Health, Dental, Vision, Life and/or LTD Plan(s), but have declined coverage in one or all of the plans at this time, as I have indicated on the front of this form.

IF I AM MAKING A RECORD CHANGE ON THE FRONT OF THIS FORM:

- I certify that the information provided on the front of this form, as it relates to the membership change I've requested, is correct to the best of my information, knowledge, and belief.

OTHER:

- Addresses for dependents can be provided to your Human Resources Office if different than yours.
- Check with your Human Resources Office for information regarding continuation of coverage for your dependents in the event they become ineligible.

AUTHORIZED DMO'S (Choose one center)

CANTON, MI

DEARBORN, MI

DETROIT, MI

LANSING, MI

STERLING HEIGHTS, MI

WARREN, MI

WOODHAVEN, MI

