

**MICHIGAN CIVIL SERVICE COMMISSION
EMPLOYEE BENEFITS DIVISION**
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
Toll Free: (800) 505-5011; Fax: (517) 373-3174

APPLICATION TO CONTINUE INSURANCES

INSTRUCTIONS: You **must complete** Section II of this application and return it 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 a qualifying event or within 60 days of the date of this notice (whichever is later), you **lose your right** to continue coverage as provided by federal law, civil service policies, and state bargaining contracts.

Date Application Sent		Section I 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)				Hire Date		
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 <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 <input type="checkbox"/> 03 Divorce <input type="checkbox"/> 04 Death of Employee <input type="checkbox"/> 05 Child Ineligible <input type="checkbox"/> 07 Reduction of Hours <input type="checkbox"/> 08 Separation from Employment	LTD Rider Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Eligible for Waiver of Life Premium? <input type="checkbox"/> Yes <input type="checkbox"/> No		COBRA Coverage Option			
	LTD Date Greater Than 12 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Health Code	Dental Code				Vision Code
	Elig. Begin Date:		H	D	V	L		
	<input type="checkbox"/> Retiree Group		Medicare Eligibility <input type="checkbox"/> Applicant and/or <input type="checkbox"/> Spouse					
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)		
Children	<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 <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Duration of leave <input type="checkbox"/> Other								
The applicant may continue Dental and/or Vision coverage for <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Duration of leave <input type="checkbox"/> Other								
SECTION II – TO BE COMPLETED BY APPLICANT – Do not write in shaded areas.								
APPLICANT: Please fill out completely for yourself and your eligible dependents covered immediately before the insurance end date above. Mark boxes for insurances you wish to continue. You may only continue insurances marked X in Section I above. If eligible for LTD Rider benefits and needing Health/HMO coverage, you must mark the Health/HMO box. You may choose to not continue one or more insurances or not enroll all or some eligible dependents. Please complete this form even if you do not wish to enroll. Make and retain a copy for your records and mail to address above.								
Name(s)	Date(s) of Birth	R E L	QE	Relationship to Employee/Retiree	Health/HMO	Dental	Vision	Life (X only one, see Section I) <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> K <input type="checkbox"/> L
Applicant								
Spouse								
Children								
								App. ret. Proc. by:
I agree to the terms and conditions of this application and understand that I forfeit 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. [Check <u>only</u> one box.]								
<input type="checkbox"/> I wish to enroll as noted in Section II.								
<input type="checkbox"/> I do not wish to enroll.								
Applicant's Signature						Date		

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IMPORTANT: TERMS AND CONDITIONS FOR CONTINUING YOUR INSURANCES

You must accurately and promptly complete this application, so the Employee Benefits Division (EBD) can verify continuation of requested insurances. You should return this form even if you do not wish to enroll in any insurance. Mail the completed application to the above address within 7 days, especially if you anticipate filing claims within the month. Waiting will delay notification to insurance plan administrators that process and pay insurance claims. If the form is not received by the EBD by the due date in the upper-right corner, you will **not** be eligible to continue 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.

Upon receipt of your application, the EBD will send you billing invoices for the fiscal year for the coverages you select. If you do not receive your invoices or an acknowledgement letter from EBD within 30 days after you submit the form, please call (517) 373-7977 or (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 invoices. 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 EBD 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 EBD 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; or (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 children may be covered under Health, HMO, Dental, and Vision plans if they meet the following eligibility criteria:

Spouse — Your legal husband or wife may be covered as a "dependent" if 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 eligible children by birth, legal adoption or legal guardianship may be covered.

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, etc.). Contact your Personnel Office or Civil Service Employee Benefits for forms.

No person (spouse or child) will be considered a "dependent" while 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, please call the EBD at (517) 373-7977 or (800) 505-5011 or the Michigan Relay Service at (800) 649-3777.