



Department of Management & Budget  
 Office of Retirement Services  
 www.michigan.gov/ors (800) 381-5111  
 P.O. Box 30171  
 Lansing MI 48909-7671

# Insurance Enrollment/Change Request

For Judges Retirees

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN	DAYTIME TELEPHONE ( )
MAILING ADDRESS	OFFICE USE ONLY	
	H / /	MAPD / /
CITY, STATE, ZIP CODE	VBR / /	MA / /
	DDR / /	

Use this form to enroll in one or more of the retirement system insurance plans, change from one health plan to another, or add, delete, or change a name for anyone on your existing insurance coverage. Also use this form to notify the Office of Retirement Services (ORS) if you or any of your covered dependents become eligible for Medicare or other health, dental, vision or prescription group insurance coverage.

## Section I: Current Insurance Coverage

### Insurance Plans and Coverage Available

If you wish to *enroll* in plan coverage or *change* your insurance plan enrollment, check the "enroll" box for the plan you are selecting and indicate who you wish to have covered under that plan. If you are *declining* coverage, you must check the "decline" box. If you wish to *cancel* insurance coverage, see *Canceling Insurance Coverage* below.

Please indicate the *earliest* effective date for your insurances to begin. There is a six-month waiting period unless you have a qualifying event so your actual effective date may differ from your desired date. ORS will determine your actual insurance effective date based on your qualifications. (See the instructions.)

<b>BCBSM</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<b>Effective Date</b> /01/	(Check all that apply.)		
<b>Dental</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	/01/	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<b>Vision</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	/01/	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)

### Canceling Insurance Coverage

If you wish to *cancel* insurance coverage, complete the information below for those individuals you are removing. If you are making no other changes to your coverage, go to Section IV, sign the form and return it to ORS.

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #
QUALIFYING EVENT: <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	RELATIONSHIP:

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #
QUALIFYING EVENT: <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	RELATIONSHIP:

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #
QUALIFYING EVENT: <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	RELATIONSHIP:

Name: \_\_\_\_\_

SSN or Member ID: \_\_\_\_\_

## *Insurance Enrollment/Change Request for Judges Retirees (continued)*

### **Section II: Self and Dependent Coverage Data**

Complete the following information about yourself and dependents you wish to enroll. You will need to provide proofs for dependents. See the instructions for details on eligible dependents and required proofs.

If you or any of your dependents will be covered under another insurance plan, including Medicare, as of the effective date of this coverage, you must indicate that additional coverage below. Indicate below the Medicare effective date from the card, if applicable, and include a copy of the Medicare card.

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
QUALIFYING EVENT: <input type="checkbox"/> ADOPTION <input type="checkbox"/> BIRTH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> OTHER	DATE OF EVENT:	RELATIONSHIP:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A                      PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> DRUG <input type="checkbox"/> VISION		

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
QUALIFYING EVENT: <input type="checkbox"/> ADOPTION <input type="checkbox"/> BIRTH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> OTHER	DATE OF EVENT:	RELATIONSHIP:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A                      PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> DRUG <input type="checkbox"/> VISION		

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
QUALIFYING EVENT: <input type="checkbox"/> ADOPTION <input type="checkbox"/> BIRTH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> OTHER	DATE OF EVENT:	RELATIONSHIP:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A                      PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> DRUG <input type="checkbox"/> VISION		

### **Section III: Name Change**

If you have a name change, indicate that change below. Please provide legal documentation of your name change such as a copy of a marriage certificate or social security card. Then sign in Section IV.

FORMER NAME (LAST, FIRST, MIDDLE)	NEW NAME (LAST, FIRST, MIDDLE)
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### **Section IV: Certification**

*I certify that the above information is correct to the best of my knowledge and belief. By my signature below I also agree to the Conditions of Enrollment specified in this form's instructions.*

PENSION RECIPIENT/CONTRACT HOLDER SIGNATURE	DATE
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# Insurance Enrollment/Change Request Instructions

## For Judges Retirees

### Enrolling In or Changing Insurance

Use this form to enroll in or change your insurance plans. Your cost for insurance premiums, shown on the current insurance rate sheet, is deducted from your monthly pension payment.

You may also enroll in the state's dental and/or vision plan. The total premium for dental and vision coverage can be deducted from your monthly pension payment.

**Enrolling After Retirement.** Pension recipients who did not enroll in one or more of the retirement system insurance plans as part of the initial application must use this form to enroll. Currently enrolled pension recipients who are changing from one health care plan to another must also complete this form.

### Self and Dependent Coverage Data

Complete all requested information for each person who will be covered under your insurance plans. If anyone is enrolled in Medicare, provide that person's Medicare card number and the effective dates of coverage for both Medicare Part A and Part B. Please send ORS a copy of the Medicare card for anyone who is under age 65.

#### Eligible Dependents

Coverage for your eligible dependents is the same as yours. Eligible dependents for health, dental, and vision plans include:

**Your spouse** as long as he or she is not also separately enrolled as an eligible state employee or retiree.

**Your unmarried children** by birth, legal adoption, or legal guardianship who are in your custody and dependent on

### Qualifying Events

The following are considered qualifying events for the purpose of adding/deleting a dependent. You must submit the indicated proof with this application. *Photocopies are acceptable.*

**Adoption.** Acceptable proof is adoption papers. In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

**Birth.** Acceptable proof is a birth certificate.

**Death.** Acceptable proof is an original death certificate.

**Divorce.** Acceptable proof is divorce papers.

Regardless of the insurance plan(s) you select, your coverage for yourself and any dependents will begin on the first day of the sixth month after ORS receives all required forms and proofs. For example, if we receive your *Insurance Enrollment/Change Request* form with the necessary proofs of eligibility on February 10, your coverage would begin August 1.

We can waive the waiting period if you or a dependent has an involuntary loss of other group coverage or a change in your family status. If we receive your *Insurance Enrollment/Change Request* form, along with proof of your loss of coverage, within 30 days of the event, there will be no gap in your coverage.

you for support. Coverage ceases the end of the month in which they turn 19. However, if your coverage is still active, your dependent child can remain eligible through the month in which the child turns 25 if he or she is:

- Unmarried and between the ages of 19 and 25.
- Dependent on you for financial support.
- A student who regularly attends school.

If your enrolled dependent is an incapacitated child, coverage will continue as long as he or she became incapacitated before age 19, continues to be incapacitated, and your coverage does not terminate for any other reason. Incapacitated children are those who are unable to earn a living because of a mental or physical impairment and must depend on their parents for support and maintenance.

**Marriage.** Acceptable proof is a marriage certificate.

#### Involuntary loss of coverage in another group plan.

Provide a statement on letterhead from the terminating group insurance plan explaining who was covered, why coverage is ending, and the date it ends.

#### Adjustments to Premiums

If you are changing insurance coverage, ORS will adjust your premiums, if needed, the month your insurance becomes effective. We cannot refund premiums withheld before or in the month you report the change. If you are adding a spouse or dependent, there is a 6-month waiting period unless you have a qualifying event. The 6-month waiting period may be waived if you submit this form and required proofs within 30 days of the qualifying event.



[www.michigan.gov/ORSJudgesDB](http://www.michigan.gov/ORSJudgesDB)



P.O. Box 30171  
Lansing, MI 48909-7671



(517) 322-5103 (Local)  
(800) 381-5111

## Insurance Enrollment/Change Request Instructions (Continued)

### Required Proofs for Dependent Coverage

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You must provide birth certificates as proof of age and relationship, tax returns as proof of dependency, school records as proof of attendance, and court orders to prove legal guardianship.

If your dependent is a disabled child age 19 or older, we will also need a current letter from the attending physician

stating the child is disabled and incapable of self-sustaining employment, along with any medical records or reports that substantiate the disability, and a copy of the IRS form 1040 that identifies the child as your dependent. In addition, every year ORS may ask you to furnish proof of incapacitation and dependency.

### Reporting Other Insurance Coverage Including Medicare

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If you or your dependents enroll in other health insurance plans, including Medicare, it is your responsibility to notify ORS of any changes in your status or that of your family that may affect eligibility and/or coverage. If anyone on your plan(s) currently has Medicare, you must complete the Medicare information on the front of this form.

**Enrolling in Medicare.** When you become eligible for Medicare you will be enrolled in Medicare Part A (hospital) and B (medical). The Medicare Plus Blue Group plan will administer your coverage. (For most people, Medicare begins at age 65 or after 24 months of social security disability eligibility.) If you do not enroll in Medicare Part B, you will remain in the State Health Plan and be personally responsible for any medical expenses that would be covered by Medicare Part B.

If you or your covered dependents become eligible for Medicare before the age of 65 you must send ORS a copy of

the Medicare card along with your social security number so that your coverage and premiums can be adjusted. ***It is your responsibility to notify ORS promptly when you enroll in Medicare.*** ORS cannot make adjustments for premiums paid prior to receipt of your Medicare card.

Medicare D is a prescription drug program introduced by the federal government in 2006. **DO NOT SIGN UP FOR MEDICARE D.** Your State Health Plan includes prescription drug benefits as part of your health care coverage.

**Coordination of Benefits.** Your health, dental, and vision plans contain a coordination of benefits (COB) provision, which says you can't be reimbursed for more than the allowed cost of your care or service. If you or your dependents are covered under another group plan, the plans coordinate their reimbursement so that their combined payments don't exceed the allowed costs.

### Conditions of Enrollment

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By enrolling in these insurances, you and your family members are bound by all conditions stated in the plan. You agree to notify ORS of any changes in your status and that of your family that may affect eligibility and/or coverage. You agree that if claims are paid on an ineligible individual, the cost of such claims may be deducted from future pension checks.

You authorize the administrator selected by ORS to obtain from providers of service any and all records and other information relating to you and your covered family members. You understand such information may be made available to ORS, on a confidential basis, for the purpose of evaluating the operation and efficiency of the plans and providers. The duration of this authorization extends for the period of your coverage under the plan.

### Group Insurance Contact Information

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**State Health Plan** - Blue Cross Blue Shield of Michigan  
P.O. Box 80380, Lansing, MI 48908-0380  
(800) 843-4876 or (517) 322-9515      Group #81828

Prescription coverage - Express Scripts' Participating Pharmacy ID Card Plan Prescription Co-Pay Card & Mail Order Pharmacy. Visit Express Scripts' website: [www.express-scripts.com](http://www.express-scripts.com) or call them at (800) 505-2324.

**State Dental Plan** - Delta Dental Plan of Michigan  
P.O. Box 9085, Farmington Hills, MI 48333-9085  
(800) 524-0150      Group #8600

**Options Mental Health**  
(for retirees enrolled in the State Health Plan)  
P.O. Box 12698, Norfolk, VA 23541-0698  
(800) 277-1122

**State Vision Plan** - Blue Cross Blue Shield of Michigan  
P.O. Box 80380, Lansing, MI 48908-0380  
(800) 843-4876 or (517) 322-9515      Group #81828