



Insurance Enrollment/Change Request

For Public School Retirees

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

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 drug group insurance coverage.

Section I: Current Insurance Coverage

Insurance Plans and Coverage Available

To enroll in health care, check the box for the provider you are selecting. You can choose either BCBSM, with or without prescription drug coverage, or an HMO, which includes drug coverage. (If you are enrolling in an HMO, please contact the HMO for an application and include it with this application.) Also check the box for dental/vision if you wish to add that insurance. Please indicate the *earliest* effective date for your insurances to begin. Effective dates are always the first of the month. ORS will determine your actual insurance effective date based on your qualifications.

I WISH TO ENROLL IN OR CHANGE MY INSURANCE TO:						
<input type="checkbox"/> BCBSM WITH DRUG	<input type="checkbox"/> BCBSM WITHOUT DRUG	<input type="checkbox"/> HAP (HMO)	<input type="checkbox"/> BCN (HMO)	<input type="checkbox"/> PRIORITY HEALTH (HMO)	<input type="checkbox"/> DENTAL/VISION	
HEALTH PLAN COVERAGE	EFFECTIVE DATE? /01/	WHO IS TO BE COVERED? CHECK ALL THAT APPLY.				
BCBSM DRUG COVERAGE	/01/	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD(REN)	<input type="checkbox"/> PARENT	
DENTAL/VISION COVERAGE	/01/	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD(REN)	<input type="checkbox"/> PARENT	

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:





Insurance Enrollment/Change Request Instructions

For Public School Retirees

Enrolling In or Changing Insurance After Retirement

Use this form to enroll in one or more of the retirement system insurance plans, change from one health plan to another, or update your dependent coverage. Indicate on this application the earliest date you wish to have your insurance be effective. Prescription drug insurance is part of your Health Maintenance Organization (HMO) coverage. You can add prescription drug coverage if you enroll in Blue Cross Blue Shield of Michigan (BCBSM).

If you were subject to a delayed insurance premium subsidy at retirement and wish to have your enrollment coincide with your insurance subsidy eligibility date, you must submit this form at least six months before that date.

Enrolling in an HMO. If you are considering an HMO for your health care provider, refer to the *Insurance Options Summary* (R0379C) for provider information and details about coverage. To enroll in an HMO, obtain an application from the HMO and include it with this application. Be sure to also check the appropriate box on page 1 of this form to indicate the insurance plan in which you're enrolling.

Enrolling yourself and/or another dependent for the first time. If you are enrolling yourself, your spouse, or another dependent in the retirement system's insurance *after* retirement, that coverage 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 and HMO enrollment form, if applicable, 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 and HMO enrollment form, if needed, along with proof of your loss of coverage, within 30 days of the event, there will be no gap in your coverage.

Changing plans. If you are currently enrolled in an HMO, you must remain in the HMO for at least six months, unless the coverage is no longer available because of a move. To change from an HMO to BCBSM, complete this form and return it to ORS along with all required proofs.

To switch from one HMO to another HMO or change from BCBSM to an HMO, request an application from the HMO and return it to ORS along with this form and all necessary proofs. **DO NOT** return your application to the HMO.

Coverage in the new plan will begin the first day of the second month after ORS receives your materials. For example, if we receive your application and proofs on February 10, your coverage will begin on April 1.

Self and Dependent Coverage Data

Complete all requested information for each person who will be covered under your insurance plans. If anyone is enrolled, or will be enrolled in Medicare by your retirement effective date, provide the Medicare claim number from your Medicare card and the effective dates for **both** Medicare Part A **and** Part B. Include a copy of the card for anyone under age 65.

Eligible Dependents.

Health, prescription drug, dental, and vision coverage for your eligible dependents is the same as yours. Those eligible are:

- Your spouse. If he or she is an eligible public school retiree, you will be covered under one contract.

- Your unmarried child by birth or legal adoption, through December 31 of the year in which he or she turns age 19.
- Your unmarried child by legal guardianship until age 18.
- Your unmarried child by birth or legal adoption from age 19 through December 31 of the year in which he or she reaches age 25, if a full-time student and dependent on you for support.
- Your unmarried child by birth or legal adoption age 19 or older who is totally and permanently disabled, dependent on you for support, and incapable of self-sustaining employment.
- Either your parent(s) or your parent(s)-in-law residing in your household — one set of parents, not both.

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.



www.michigan.gov/ORSschools



PO Box 30171
Lansing MI 48909-7671



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

Insurance Enrollment/Change Request Instructions (Continued)

Death. Acceptable proof is a death certificate.

Divorce. Acceptable proof is divorce papers.

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 coverage 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.

If you enrolled in insurances before your insurance premium subsidy effective date and are paying the full premium, ORS will automatically reduce your insurance premium on your premium subsidy effective date.

Required Proofs for Dependent Coverage

You must provide your marriage certificate if married and birth certificates as proof of age and relationship. Tax returns are required 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.

Proof of residence is required for a parent who lives with you. Provide a 1099 or 1098, driver's license, or state-issued ID showing the parent resides with you.

Reporting Other Insurance Coverage Including Medicare

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.

Your health, prescription drug, 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.

Sign up for Medicare. As soon as you or any of your covered dependents become eligible for Medicare, you must enroll in both Part A and Part B. For most, Medicare begins at age 65 or after two years of social security disability eligibility. If Medicare eligibility happens before age 65, immediately enter the Medicare

information online through miAccount or complete this form with your Medicare Claim number and effective date. *It is your responsibility to notify ORS promptly when you enroll in Medicare.* ORS cannot make adjustments for premiums paid prior to receipt of this *Insurance Enrollment/Change Request*.

Your health plan coordinates with Medicare. If you don't enroll in Medicare Part B, you will be personally responsible for any medical expenses that would be covered by Medicare. Your retirement system health plan will continue to pay for any of the plan's covered benefits that are not covered by Medicare.

Medicare part D is a prescription drug program introduced by the federal government in 2006. **Do not sign up for Medicare Part D.** Your insurance carrier will automatically enroll you in Medicare Part D if appropriate. Be sure your insurance carrier knows your Medicare number.

Conditions of Enrollment

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.