



# MICHIGAN OFFICE OF RETIREMENT SERVICES

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

www.michigan.gov/ors

800-381-5111  
517-322-5103

## Insurance Enrollment/Change Request – State Retirees

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN	PHONE NUMBER ( )
PHYSICAL ADDRESS (CANNOT BE A PO BOX)	COUNTY OF RESIDENCE	
CITY, STATE, ZIP CODE	EMAIL ADDRESS	

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 other health, prescription drug, dental, or vision group insurance coverage, including Medicare if enrolling before age 65.

### Section I – Enrolling in Insurances

Mark the appropriate boxes below for the insurance plan(s) in which you wish to enroll and who you want covered. 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 for more details).

<b>Health Plan</b>	ENROLL <input type="checkbox"/>	Effective Date /01/	(Check all that apply) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)
<b>IF ENROLLING IN A HEALTH PLAN, PLEASE CHOOSE ONE FROM THE FOLLOWING:</b>			
<input type="checkbox"/> BCBSM WITH PRESCRIPTION DRUG PLAN	HMO (PRESCRIPTION DRUG PLAN INCLUDED):		
<input type="checkbox"/> BCBSM WITHOUT PRESCRIPTION DRUG PLAN	<input type="checkbox"/> BCN	<input type="checkbox"/> HAP	<input type="checkbox"/> PRIORITY HEALTH <input type="checkbox"/> PHYS HEALTH PLAN
<b>Dental Plan</b>	ENROLL <input type="checkbox"/>	Effective Date /01/	(Check all that apply) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)
<b>Vision Plan</b>	ENROLL <input type="checkbox"/>	Effective Date /01/	(Check all that apply) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)

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. Copy the Medicare information from the Medicare card for anyone you are covering. Attach additional sheets if necessary.

ENROLLEE NAME (LAST, FIRST, MIDDLE)	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:	
MEDICARE INSURANCE COVERAGE? <input type="checkbox"/> Y <input type="checkbox"/> N (IF N, LEAVE THIS LINE BLANK)	MEDICARE CLAIM #	MEDICARE, EFFECTIVE DATES PART A                      PART B	
OTHER INSURANCE COVERAGE? <input type="checkbox"/> Y <input type="checkbox"/> N (IF N, LEAVE THIS LINE BLANK)	POLICY #	CARRIER NAME/COVERAGE TYPE	
ENROLLEE NAME (LAST, FIRST, MIDDLE)	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:	
MEDICARE INSURANCE COVERAGE? <input type="checkbox"/> Y <input type="checkbox"/> N (IF N, LEAVE THIS LINE BLANK)	MEDICARE CLAIM #	MEDICARE, EFFECTIVE DATES PART A                      PART B	
OTHER INSURANCE COVERAGE? <input type="checkbox"/> Y <input type="checkbox"/> N (IF N, LEAVE THIS LINE BLANK)	POLICY #	CARRIER NAME/COVERAGE TYPE	





## Insurance Enrollment/Change Request – State Retirees

### *Instructions*

#### **Enrolling in or Changing Insurance after Retirement**

**Personal Healthcare Fund.** If you have the Personal Healthcare Fund, you can only use this form to change plans. You cannot enroll after you have retired. If you're not sure if you have the Personal Healthcare Fund, log into miAccount at [www.michigan.gov/orsmiaccount](http://www.michigan.gov/orsmiaccount).

**Enrolling in an HMO.** If you are considering an HMO for your health care provider, refer to the *Health, Dental, Vision, and Life Insurance Options (R0423GH)* sheet for provider information and coverage details.

**Effective Dates** If you have the premium subsidy benefit and enroll after your retirement effective date, there will be a six month wait before your insurance can start. Your insurance will start six months after we receive your new insurance enrollment request and all required proofs. For example, if we get your request and proofs on February 10, your coverage would start August 1.

The waiting period does not apply if you or a dependent has a qualifying event and ORS gets the request and proofs within 30 days of the qualifying event. For retirees who do not have Medicare, coverage can begin the first of the month after the month we receive your completed application and proofs. For retirees with Medicare, if get your request and proofs by the 15<sup>th</sup> of the month, we will enroll you the following month. If we get the request and proofs later, but within 30 days of the qualifying event, you may not be enrolled until a month later.

**Changing plans.** To change your insurance plan, log in to miAccount and click on Insurance Coverage, or complete an *Insurance Enrollment/Change Request (R0452G)* and return it to ORS along with all required proofs. 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 you have moved out of the coverage area.

Coverage will begin the first day of the month after ORS receives your materials if you are enrolling in BCBSM or moving out of an HMO coverage area. Coverage will begin the first day of the second month if you are voluntarily changing HMOs.

**Adjustments to Premiums.** ORS will adjust your premiums, if needed, the month any insurance changes take effect. We cannot refund premiums withheld before or in the month you report the change. If you enrolled in insurances before your subsidy effective date and are paying the entire premium, ORS will automatically reduce your premium on your subsidy effective date.

#### **Self and Dependent Coverage – Eligibility and Proofs**

**Eligible dependents** for health, dental, prescription drug, and vision insurance 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 full legal guardianship (until age 18) who are in your custody and dependent on you for support.

Coverage for all other dependents 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 the child turns 26 or graduates, whichever occurs first, if he or she is:

- Unmarried and between the ages of 19 and 26.
- Dependent on you for at least 50% of financial support.
- Enrolled at least half-time in an accredited educational institution.

**Proofs.** Provide your marriage certificate if married and spouse's and dependents' 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 full legal guardianship.

If your enrolled dependent is a disabled child, coverage will continue as long as he or she was totally and permanently disabled before age 19, continues to be disabled, and your coverage does not terminate for any other reason. Provide a current letter from the attending physician stating the child is totally and permanently disabled and incapable of self-sustaining employment and detailing the disability, and the IRS form 1040 that identifies the child as your dependent. In some cases we may ask for additional information to determine medical eligibility, which may delay enrollment. You may also be asked to furnish proof of disability and dependency each year.

## Insurance Enrollment/Change Request – State Retirees

### *Instructions (cont)*

#### **Qualifying Events**

The following are considered qualifying events for the purpose of adding/deleting a dependent. You must submit proofs 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.

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

**Death.** Acceptable proof is an original 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 it ends.

#### **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.

**Sign up for Medicare.** As soon as you or anyone else covered by your health insurance becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical). You must have Medicare Parts A and B to enroll in retiree insurance and prescription drug programs. If you, your spouse, or your dependents don't enroll in Medicare Part B when first eligible, the insurance for that person will be canceled and there is a six month wait to re-enroll.

For most people, Medicare begins at age 65 or after 24 months of social security disability. If that happens before age 65, send ORS this form, and make sure ORS has your Medicare number.

Medicare Part D (prescription drug) is a federal program that is administered by your group insurance plan. When you enroll in a state retiree prescription drug plan, we will automatically enroll you in Medicare Part D if appropriate.

ORS cannot enroll you retroactively in the state health plan once you're eligible for Medicare.

#### **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.