

Name: _____

SSN or Member ID: _____

**Insurance Enrollment/Change Request
for State Defined Contribution Participants (continued)**

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		

Dual Insurance Coverage

Is your spouse a participant of the State Employees Retirement System? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, you and your spouse will be covered under a single contract. Please provide your spouse's social security number if it is not listed above. _____
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Section III: 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 V, 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

Section IV: 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 V.

FORMER NAME (LAST, FIRST, MIDDLE)	NEW NAME (LAST, FIRST, MIDDLE)
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Section V: Certification (Your signature is required.)

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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Mail application and all documents to: ORS, P.O. Box 30171, Lansing, MI 48909-7671



Insurance Enrollment/Change Request Instructions

For State Defined Contribution Participants

Enrolling In or Changing Insurance

Use this form to enroll in one or more of the insurance plans, change from one health plan to another, or update your dependent coverage.

Declining Insurances. If you do not wish to enroll in either the health, dental, or vision insurance plans, check the DECLINE box(es), then sign and date in Section V. You can enroll later, but may have a six-month waiting period. See *Enrolling for the first time* below for details.

Enrolling in an HMO. If you are considering a Health Maintenance Organization (HMO) for your health care provider, refer to the *Health, Dental, Vision, and Life Insurance Options (R0423G)* sheet for provider information and coverage details. If you decide to enroll in an HMO, contact the HMO directly for an application and include it with this application. Be sure to mark ENROLL on the HMO line on the front of this application to indicate your enrollment data is on a separate application.

Enrolling for the first time. If you are enrolling yourself, your spouse, or another dependent in the retirement system's insurance *after* there's been a gap in coverage, your 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 (R0452G) 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 you meet the requirements and we receive your *Insurance Enrollment/Change Request* (and HMO enrollment form if enrolling in an HMO) along with loss of coverage proof within 30 days of the event, there will be no gap in your coverage.

Changing plans. To change from an HMO to BCBSM, complete this form and return it to ORS along with all required proofs. There is a six-month waiting period unless you have a qualifying event.

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

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 or legal adoption who are in your custody and dependent on you for support. Coverage ceases the end of the year in which they turn 18. However, if your coverage is still active, your dependent child can remain eligible through the year in which the child turns 23 if he or she is:

- Unmarried and between the ages of 18 and 23;
- Dependent on you for financial support; and
- A full-time student.

You can enroll your child over age 18 in insurances if the child is determined to be totally and permanently disabled and dependent on you for support. You must furnish proof of disability along with proof your child lived with you for more than half the year and you provided more than half the child's financial support for the year. Coverage can continue as long as there is no break in eligibility.

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:** adoption papers, a sworn statement with the date of placement, or a court order verifying

placement. In a legal adoption, a child is eligible for coverage as of the date of placement – when you become legally obligated for the total or partial support of the child in anticipation of adoption.

- **Birth:** birth certificate.
- **Death:** original death certificate.



www.michigan.gov/ORSstateDC



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



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

Insurance Enrollment/Change Request Instructions

- **Divorce:** divorce papers.
- **Marriage:** marriage certificate.
- **Involuntary loss of coverage in another group plan:** statement from the terminating group insurance plan (on letterhead) explaining who was covered, why coverage is ending, and the date it ends.

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 six-month waiting period unless you have a qualifying event. The six-month waiting period may be waived if you submit this form and required proofs within 30 days of the qualifying event.

Required Proofs for Dependent Coverage

You must provide birth certificates as proof of age and relationship, tax returns as proof of dependency, and school records as proof of full-time attendance.

If your dependent is a disabled child age 18 or older, we will need a current letter from a physician stating the child is totally and permanently disabled, 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 you may be asked to furnish proof of disability and dependency.

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. 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 *must* enroll in Medicare Part A (hospital) and B (medical). The Medicare Advantage 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 complete this

form with your Medicare number and effective date. *It is your responsibility to notify ORS promptly by completing this form when you enroll in Medicare.* ORS cannot enroll you retroactively in the Medicare Advantage plan, nor can we make adjustments for premiums paid prior to receipt of this *Insurance Enrollment/Change Request*.

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 with your health 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

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, you may be responsible for the cost of such claims.

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.