MICHIGAN OFFICE OF RETIREMENT SERVICES
PO Box 30171 · Lansing, MI 48909-7671
Michigan.gov/ORS
Toll Free: 800-381-5111
Fax: 517-284-4416

Insurance Enrollment/Change Request – For State Defined Contribution Participants

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

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SOCIAL SECURITY NUMBER	PHONE NUMBER
MAILING ADDRESS		**COUNTY**
CITY, STATE, ZIP CODE	**EMAIL ADDRESS**	

Section I: Insurance Options

Are you declining insurance coverage at this time? ☐ **YES-DECLINE** ☐ **NO-ENROLL**. If declining coverage, proceed to Section III. If enrolling in insurance coverage, continue.

Check the box for the insurance plan you want to enroll in, and indicate when you want your coverage to start and who you want to enroll. (Note: Start dates are always the first of the month.) Your start date depends on when you submit your insurance request and required proofs, and if you have a qualifying event. See the instructions for details. ORS will verify your start date when we process your insurance request.

	HEALTH PLAN	START DATE	WHO TO ENROLL? (Check all that apply.)
	If enrolling in a health plan, choose one of the following:	_____/01/_____	☐ Self ☐ Spouse ☐ Child(ren)
☐	Blue Cross Blue Shield of Michigan with prescription drug plan		
☐	Blue Cross Blue Shield of Michigan without prescription drug plan		
☐	Blue Care Network, includes prescription drug plan (HMO)		
☐	Health Alliance Plan, includes prescription drug plan (HMO)		

DENTAL, VISION PLANS	START DATE	WHO TO ENROLL? (Check all that apply.)
☐ Delta Dental	_____/01/_____	☐ Self ☐ Spouse ☐ Child(ren)
☐ EyeMed	_____/01/_____	☐ Self ☐ Spouse ☐ Child(ren)

Section II: Enrollee Information

Provide the following information for each person you're enrolling on your insurance. Attach additional pages if necessary. Submit required proof(s) for each enrollee. See the instructions for details on eligible family members and required proofs.

ENROLLEE INFORMATION NO. 1

Self ☐	Spouse ☐	Child ☐	

Enrollee name (last, first, M.I.)

Social Security number | **GENDER** ☐ M ☐ F

Birthdate

QUALIFYING EVENT		Qualifying event date
☐ Adoption	☐ Birth	
☐ Marriage	☐ Other	

OTHER INSURANCE (including Medicare)

Carrier name (including Medicare)

Medicare number or policy number

Medicare effective dates or other policy start date

Part A	Part B

COVERAGE TYPE

Health ☐	Prescription ☐	Dental ☐	Vision ☐

End-stage renal disease? ☐ Yes ☐ No

ENROLLEE INFORMATION NO. 2

Self ☐	Spouse ☐	Child ☐	

Enrollee name (last, first, M.I.)

Social Security number | **GENDER** ☐ M ☐ F

Birthdate

QUALIFYING EVENT		Qualifying event date
☐ Adoption	☐ Birth	
☐ Marriage	☐ Other	

OTHER INSURANCE (including Medicare)

Carrier name (including Medicare)

Medicare number or policy number

Medicare effective dates or other policy start date

Part A	Part B

COVERAGE TYPE

Health ☐	Prescription ☐	Dental ☐	Vision ☐

End-stage renal disease? ☐ Yes ☐ No

Physical address

The Centers for Medicare and Medicaid Services requires a physical address when enrolling in insurance coverage with ORS. Provide your physical address, including the county of your residence. You cannot be enrolled in insurance with only a post office (PO) box or private mailbox. If your physical address is different than your mailing address, provide your mailing address at the top of this form.

PHYSICAL ADDRESS (CANNOT BE A PO BOX OR PRIVATE MAILBOX)	**COUNTY**
CITY, STATE, ZIP CODE	

Section III: Canceling Insurance Coverage

Note: If you have the Personal Healthcare Fund and you disenroll from the plan at any time, you, your spouse, and your dependents will not be able to reenroll. Provide the following information for each person you're removing from your insurance coverage. Terminations are never retroactive. If you provide a retroactive termination date, the termination date will be the last day of the month ORS received the form.

ENROLLEE NAME NO. 1 (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	RELATIONSHIP	TERMINATION DATE

PLAN TO CANCEL	☐Health	☐Prescription	☐Dental	☐Vision
QUALIFYING EVENT	☐Death	☐Divorce	☐Other	

ENROLLEE NAME NO. 2 (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	RELATIONSHIP	TERMINATION DATE

PLAN TO CANCEL	☐Health	☐Prescription	☐Dental	☐Vision
QUALIFYING EVENT	☐Death	☐Divorce	☐Other	

Section IV: Name/Address Change

If you have a name and/or address change, indicate that change below. For a name change, provide legal documentation such as a copy of a marriage certificate, divorce decree, court order, or a replacement Social Security card.

NEW LAST NAME	FIRST NAME	M.I.

NEW PHYSICAL ADDRESS (CANNOT BE A PO BOX OR PRIVATE MAILBOX)	APT OR SUITE

CITY, STATE, ZIP CODE	COUNTY

NEW MAILING ADDRESS ☐ (CHECK IF SAME AS PHYSICAL ADDRESS AND LEAVE BLANK)	APT OR SUITE

CITY, STATE, ZIP CODE	COUNTY

Section V: Certification (*Required*)

By my signature below, I certify that the above information is correct to the best of my knowledge and belief and that I agree to the following conditions of enrollment:

- *By enrolling in the insurance plans, I understand that my family members and I are bound by all conditions stated in the plan.*
- *I agree to notify ORS of any changes in my status and that of my family that may affect eligibility and/or coverage.*
- *I agree that if claims are paid on an ineligible individual, the cost of such claims may be deducted from future supplemental benefit payments.*
- *I authorize the administrator selected by ORS to obtain from providers of service any and all records and other information relating to me and my covered family members.*

MEMBER'S SIGNATURE	DATE

Section VI: Supplemental Information (*Optional*)

Answering these questions is optional. You can't be denied coverage because of your responses or if you don't complete this section.

If you need your plan documents in an accessible format, select your preferred format below.			
☐ Braille	☐ Large print	☐ Audio CD	☐ Data CD

For individuals helping enrollee complete this form.				
Complete this section if you're an individual — i.e., agent, broker, State Health Insurance Assistance Program (SHIP) counselor, family member, or other third party — helping the enrollee fill out this form. National Producer Number is required for agents or brokers.				
Name:				
Relationship to enrollee:				
☐ Agent	☐ Broker	☐ SHIP counselor	☐ Family member	☐ Third party
National Producer Number **(required for agents/brokers):**				

Return your completed form to: ORS, PO Box 30171, Lansing, MI 48909-7671 or fax to 517-284-4416.

When Coverage Starts

Personal Healthcare Fund. If you have the Personal Healthcare fund, you are not eligible for subsidized health, prescription drug, dental, or vision insurances through the retirement system.

You, your spouse, and your dependents may enroll in insurances if you enroll immediately when you retire but you will be responsible for the entire premium. If you disenroll from the plan at any time, you, your spouse, and your dependents will not be able to reenroll. If your spouse or dependents are disenrolled at any time, they will not be able to reenroll.

Declining insurances. If you do not want to enroll in either the health, dental, or vision insurance plans, check the DECLINE box, then sign and date in Section V.

Enrolling at retirement. Insurance coverage always begins on the first day of a calendar month. For retirees who do not have Medicare, coverage can begin the first of the month after we receive your completed application and proofs. For retirees with Medicare, coverage can begin the first day of the second month after we receive your request and any required proofs. For example, if ORS receives your application and proofs July 10, your coverage will begin September 1. If we get the request and proofs later but within 30 days of your retirement effective date, you may not be enrolled until a month later.

Enrolling after retirement. If you are enrolling your spouse or a dependent in insurance after retirement, 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 (R0752G)* form with proofs February 10, your coverage will begin August 1.

The waiting period does not apply if you, your spouse, or a dependent has a qualifying event and ORS gets the request and proofs within 30 days of the qualifying event. For retirees with Medicare, coverage can begin the first day of the second month after we receive your request and any required proofs, including proof of the qualifying event. For example, if ORS receives your application and proofs of qualifying event July 10, your coverage will begin September 1. 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. If you are currently enrolled in any health insurance plan with the retirement system, you can change your enrollment to another plan regardless of your Medicare status. Your change in coverage will be effective the first day of the second month after ORS receives your enrollment request and required proofs. For example, if ORS receives your change request and required proofs January 10, your coverage with the new plan will start March 1.

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.

Your Spouse and Eligible Dependents

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

- Your spouse, as long as they are not also enrolled separately as an eligible state employee or retiree.
- Your child by birth, adoption, or legal guardianship.
- Your stepchild if they were covered under your active State of Michigan employee health insurance plan through your employment termination date.

If your enrolled dependent is an unmarried child by birth, adoption or legal guardianship who is totally and permanently disabled, dependent on you for support, and incapable of self-sustaining employment, their coverage will continue as long as they were totally and permanently disabled before age 26, and your coverage does not terminate for any other reason.

- In the case of legal adoption, a child is eligible for coverage as of th date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption.
- In the case of legal guardianship, official guardianship paperwork must be in place for a dependent to be eligible for coverage. Once a guardianship terminates, dependent eligibility for coverage ends.

Required Proofs for Coverage

The following proofs are needed to enroll your spouse and eligible dependents on your insurance. (Send photocopies; originals will not be returned.)

Spouse:

- Government-issued birth certificate, *or* valid passport, *or* valid driver's license.
- Government-issued marriage certificate *or* you and your spouse's valid driver's licenses showing matching addresses and your most recent tax *Form 1040* showing you filed married.

Child: Government-issued birth certificate as proof of age and relationship *or* court orders to prove legal guardianship, if applicable.

Dependent child with a disability:

- Government-issued birth certificate as proof of age and relationship *or* court orders to prove legal guardianship, if applicable.
- A current letter from the attending physician detailing the disability, stating the child is totally and permanently disabled and incapable of self-sustaining employment.
- Your most recent IRS *Form 1040* that identifies the child as your dependent.

Qualifying Events

The following are considered qualifying events for adding a spouse or eligible dependent to your insurance. You must submit required proofs with the enrollment request within 30 days of the qualifying event. (Send photocopies; originals will not be returned.)

Note: To remove a spouse or dependent from your coverage, no proofs are needed with your request.

Involuntary loss of coverage in another group plan: Acceptable proof is a statement on letterhead from the terminating group insurance plan explaining who was covered, the type of coverage it was, why coverage is ending, and the date coverage ends.

Adoption: Acceptable proof is 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. 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 government-issued birth certificate.

Death: Acceptable proof is a death certificate.

Divorce: Acceptable proof is a statement on letterhead from the terminating group insurance plan explaining who was covered, the type of coverage it was, why coverage is ending, and the date coverage ends.

Marriage: Acceptable proof is a government-issued marriage certificate.

Medicare Part B enrollment: Acceptable proof is a letter from the Social Security Administration showing confirmation of Part B enrollment. This qualifying event applies if the enrollee's insurance coverage was previously terminated or if enrollment was denied because they didn't have Part B coverage.

Reporting Other Insurance Coverage, Including Medicare

If you, your spouse, or your dependents enroll in other health insurance plans, including Medicare, **it is your responsibility to promptly notify ORS** of any changes in your status or that of your spouse or dependents 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 reenroll.

For most people, Medicare begins at age 65 or after 24 months of Social Security Disability Insurance. If that happens before age 65, for you or anyone else on your insurance, send ORS this completed form and make sure ORS has the enrollee's Medicare number.

When you enroll in Medicare you will receive your Medicare card from Social Security. As soon as you receive your card, tell ORS your Medicare number and effective dates for parts A and B.

You can submit your Medicare enrollment information one of the following ways:

- Send a secure message on the miAccount Message Board including your Medicare enrollment information.
- Update your insurance enrollment information in miAccount at **Michigan.gov/ORSmiAccount** to include your new Medicare information and send the confirmation page to ORS. (You'll use MiLogin to access miAccount.)
- Make a copy of your Medicare card. Write your name, address, and date of birth on the copy and mail or fax the copy of your card to ORS.
- Mail or fax a completed *Insurance Enrollment/Change Request (R0752G)* form to ORS with your Medicare information.
- Call ORS at **800-381-5111** and give a representative your Medicare information.

When we receive your Medicare number, ORS will enroll you in a Medicare Advantage Plan. A Medicare Advantage Plan is a private health plan that contracts with Medicare to provide you with all your Part A and Part B benefits.

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

Don't sign up for a Medicare Part D prescription drug plan or any other supplemental prescription drug plan. Doing so will result in a loss of medical and prescription drug coverage through the retirement system's plan.

ORS cannot enroll you retroactively in insurance plans once you're eligible for Medicare.

Conditions of Enrollment

By enrolling in these insurances, you and your covered 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.