



Insurance Enrollment/Change Request

For State Defined Contribution Participants with the Graded Premium Subsidy

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

Use this form to decline or 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 are declining all coverage at this time, check the DECLINE box(es) below; then go to Section IV.

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 wish to *cancel* insurance coverage, see *Canceling Insurance Coverage* below.

Mark the appropriate boxes below for the insurance plan(s) in which you wish to enroll and who you want covered. If you meet age and service requirements as a nondisability participant, you can immediately enroll yourself and your eligible dependents in state-sponsored health, dental, and vision insurances. 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.

	ENROLL	DECLINE	EFFECTIVE DATE	(Check all that apply)
BCBSM	<input type="checkbox"/>	<input type="checkbox"/>	/01/	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)
HMO	<input type="checkbox"/>	<input type="checkbox"/>	/01/	Please obtain and enclose the completed HMO application.
DENTAL PLAN	<input type="checkbox"/>	<input type="checkbox"/>	/01/	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN)
VISION PLAN	<input type="checkbox"/>	<input type="checkbox"/>	/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 CLAIM #/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 CLAIM #/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 State Defined Contribution Participants (continued)**

NAME (LAST, FIRST, MIDDLE)	MEDICARE CLAIM #/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 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. Write the Medicare effective dates for both Part A and Part B from the card, if applicable.

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:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY # OR MEDICARE CLAIM #	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)	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 # OR MEDICARE CLAIM #	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)	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 # OR MEDICARE CLAIM #	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: 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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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 **with the Graded Premium Subsidy**

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 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 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 IN HMO" on the front of this application to indicate your enrollment data is on a separate application.

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, 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 form and/or HMO enrollment 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 or HMO enrollment form, along with proof of your loss of coverage, 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 6-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

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.

Eligible Dependents

Coverage for dependents enrolled in state insurance plans at the time the member retires may continue to be enrolled. You can enroll the following eligible dependents for health, dental, and vision insurance plans when you retire:

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 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.

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



www.michigan.gov/ORSstateDC



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



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

Insurance Enrollment/Change Request Instructions

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.

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.

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 full legal guardianship.

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

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). (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.

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.

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.

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 you may be asked to furnish proof of incapacitation and dependency.

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 Supplemental State Health Plan PPO 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 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.

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.