

Please type or print **FIRMLY** with ballpoint pen.

ENROLLMENT APPLICATION

Health, Dental, Vision, Life, FSA and LTD Plans

EVENT <input type="checkbox"/> Record Change (Check one below) <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Ineligible Dependent <input type="checkbox"/> Other (Explain) Reason:	DATE OF EVENT
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SECTION A – EMPLOYEE INFORMATION

EMPLOYEE ID NO.	EMPLOYEE LAST NAME	FIRST NAME	M.I.
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ARE YOU MARRIED TO A STATE OF MICHIGAN EMPLOYEE OR RETIREE? YES NO IF YES, EMPLOYEE ID NO. AND NAME OF SPOUSE:

SECTION B – COVERAGE ELECTIONS

HEALTH	<input type="checkbox"/> State Health Plan PPO/ BCBSM	<input type="checkbox"/> Catastrophic Plan	<input type="checkbox"/> Opt Out W/Rebate*	<input type="checkbox"/> Decline Coverage W/O Rebate	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family	
	<input type="checkbox"/> HMO	IF HMO, PROVIDE NAME OF HMO							
DENTAL	<input type="checkbox"/> State Dental Plan	<input type="checkbox"/> DMO	<input type="checkbox"/> Preventive Dental Plan	<input type="checkbox"/> Opt Out W/Rebate*	<input type="checkbox"/> Decline Coverage W/O Rebate	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family
VISION	<input type="checkbox"/> State Vision Plan				<input type="checkbox"/> Decline Coverage W/O Rebate	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family
LIFE	<input type="checkbox"/> Reduced Life (One times annual salary to maximum of \$50,000) <input type="checkbox"/> Regular Life (Two times annual salary to a maximum of \$200,000*) <small>*This life insurance limit may not be applicable to employees who are covered by a collective bargaining agreement.</small>				Dependent Life Coverage <input type="checkbox"/> F – Spouse \$1,500 and/or Child(ren) \$1,000 <input type="checkbox"/> L – Child(ren) Only \$10,000 <input type="checkbox"/> G – Spouse \$5,000 and/or Child(ren) \$2,500 <input type="checkbox"/> M – Spouse \$50,000 and/or Child(ren) \$15,000 ¹ <input type="checkbox"/> H – Spouse \$10,000 and/or Child(ren) \$5,000 <input type="checkbox"/> N – Child(ren) Only \$15,000 ¹ <input type="checkbox"/> K – Spouse \$25,000 and/or Child(ren) \$10,000 <input type="checkbox"/> Waive Dependent Life Coverage <small>¹MSPTA (T01) Represented Excluded</small>				
FSA	Flexible Spending Account - Health Care Spending Account: <input type="checkbox"/> Enroll Health Care Spending Account Amt X Pay Periods = Annual Goal <input type="checkbox"/> Waive Health Care Spending Account				Flexible Spending Account - Dependent Care Spending Account: <input type="checkbox"/> Enroll Dependent Care Spending Account Amt X Pay Periods = Annual Goal <input type="checkbox"/> Waive Dependent Care Spending Account				
LTD	<input type="checkbox"/> Elect Coverage		<input type="checkbox"/> Decline Coverage		<input type="checkbox"/> I have read and understand the conditions under which long-term disability can be paid.				

SECTION C – DEPENDENT ENROLLMENT (Attach additional pages, if necessary.)

ADD	DEL	NAME	LAST	FIRST	M.I.	SOCIAL SECURITY NUMBER	RELATION TO YOU	SEX M/F	DATE OF BIRTH (MM/DD/YYYY)	COVERAGE (Y/N)			
										HEALTH	DENTAL	VISION	LIFE
<input type="checkbox"/>	<input type="checkbox"/>	SPOUSE											
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT											
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT											
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT											
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT											
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT											

I have read and agree to the applicable terms and conditions stated on the reverse side of this application	SIGNATURE OF APPLICANT	CONTACT PHONE NUMBER	DATE
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*If your spouse is a state employee/retiree, you are not eligible for an opt-out with a rebate.

IF THIS IS AN APPLICATION FOR COVERAGE:

- I certify that the information provided on the front of this application is correct to the best of my information, knowledge, and belief.
- I elect to enroll in the state-sponsored Health, Dental, Vision, Life, FSA and/or LTD Plan(s) for which I am eligible, as checked on the front of this application. I understand that this application authorizes the State of Michigan to withhold the contribution(s) required for my enrollment(s).
- I understand that I may enroll my legal spouse (with copy of marriage certificate), and unmarried children under age 19 (with copy of official birth certificate, not hospital birth certificate) in health, dental, vision, and dependent life insurance. Dependent children up to age 25 who are enrolled in an accredited educational institution (with copy of school registration or other records proving school attendance) may be enrolled in health, dental, and vision insurance. Dependent children are eligible for dependent life insurance up to age 23. Health coverage will continue automatically until the end of the month in which an eligible dependent turns 26. Eligible children include my child by birth, legal adoption, or legal guardianship; foster children placed in your home by a state agency or a court; and step-children for whom you have physical custody (i.e. live with me at least 50% of the time as stated in a current divorce decree and for whom I provide at least 50% of their support).
- I also understand that coverage that is already in place for my unmarried child will not be terminated at age 19 and over if the child is totally incapacitated, unable to earn a living because of mental or physical disabilities, and depends principally on me for support and maintenance, and that coverage is not terminated for any other reason. Proof that your child is incapacitated must be submitted prior to age 19 to your health plan administrator & the Employee Benefits Division.
- I agree to give notice of any changes in my status and status of my family members that effect eligibility. If I acquire a new eligible dependent, plan enrollment must be made either in 31 days of this event (with copy of official birth certificate, not hospital birth certificate, if newborn, marriage certificate, if new spouse, or adoption papers, if newly adopted child), or during an open enrollment period.
- I understand that no one may be insured as both an employee/retiree AND as a dependent under these state-sponsored plans; nor may two employees/retirees independently insure the same dependent(s) under state-sponsored plans.
- I authorize the Plan Administrator to obtain from providers of service any and all records and information relating to me and my family members. I understand that this information may also be reviewed by the State of Michigan.

IF I HAVE DECLINED COVERAGE ON THE FRONT OF THIS APPLICATION:

- I understand that I have been offered enrollment in the state-sponsored Health, Dental, Vision, Life, and/or LTD Plan(s), but have declined coverage in one or all of the plans at this time, as I have indicated on the front of this application.

IF I AM MAKING A RECORD CHANGE ON THE FRONT OF THIS APPLICATION:

- I certify that the information provided on the front of this application, as it relates to the membership change I've requested, is correct to the best of my information, knowledge, and belief.

OTHER:

- Addresses for dependents can be provided to your MI-HR Human Resources Office, if different than yours.
- Check with your Human Resources Office for information regarding continuation of coverage for your dependents in the event they become ineligible.