CS-1820
REV 2/2017

MICHIGAN CIVIL SERVICE COMMISSION
EMPLOYEE BENEFITS DIVISION
P.O. Box 30002
Lansing, Michigan 48909
Toll Free: 800-505-5011; **Fax: 517-284-0078**

APPLICATION TO CONTINUE INSURANCES

SECTION I – TO BE COMPLETED BY PERSONNEL OFFICE

Date Application Sent	Human Resource Preparer's name and phone number	Return by

Employee I.D. #	Name of Qualified Applicant (last, first, middle initial)	Hire Date

Applicant's Address	City	State	Zip Code	Daytime Phone #

Name of Employee/Retiree	SS # of Employee/Retiree	Dept./Agency	Unit Code	Was 2 Pay Period Prepay Used for Layoff?
	XXX-XX-			☐ Yes ☐ No

Qualifying Event Date	Insurance End Date	FMLA End Date (Dental/Vision)	LTD Rider Eligible?	Eligible for Waiver of Life Premium?
			☐ Yes ☐ No	☐ Yes ☐ No

Qualifying Event (X box that applies)

☐ Layoff ☐ Leave of Absence (Approved or Pending Approval) /Suspension ☐ Reduction of Hours

☐ Separation from Employment ☐ Child Ineligible ☐ Divorce ☐ Death of Employee

Medicare Eligibility

☐ Applicant and/or
☐ Spouse

The applicant may continue any or all of the coverages marked below:

	Health	Dental	Vision
Applicant:	☐	☐	☐
Spouse:	☐	☐	☐
Children:	☐	☐	☐

Life (Available only if applicant is employee on layoff or leave of absence)

☐ E (Employee) $_____ ☐ G (E+$5,000S $2,500/C) ☐ K (E+$25,000S $10,000/C)
☐ F (E+$1,500S $1,000/C) ☐ H (E+$10,000S $5,000/C) ☐ L (E+$10,000/C)
☐ M (E+$50,000S $15,000/C) ☐ N (E+$15,000/C)

Current Health Carrier: _____ Current Dental Carrier: _____

The applicant may continue Health coverage for: ☐ 18 months ☐ 36 months ☐ Duration of leave ☐ Other

The applicant may continue Dental and/or Vision coverage for: ☐ 18 months ☐ 36 months ☐ Duration of leave ☐ Other

SECTION II – TO BE COMPLETED BY APPLICANT

INSTRUCTIONS: Mark boxes below for yourself, and eligible dependents that were covered immediately before the insurance end date indicated above. **If you are eligible for LTD Rider benefits and need health coverage, you must mark the health box.** You may only continue insurances as marked in Section I. You may choose to not continue one or more insurances, or not enroll all or some eligible dependents. This form must be returned within 60 days of your loss of coverage, or 60 days from date of this notice (whichever is later), or you lose your right to continue coverage as provided by federal law, civil service policies, and state bargaining contracts. Fax this completed form to 517-284-0078, or mail to address above. Retain a copy of this form for your records.

Name(s)	Date(s) of Birth	Relationship to Employee/ Retiree	Health	Dental	Vision	Life Select only one (F-N includes Employee Life)
Applicant						☐ **Employee Life Only**
Spouse						☐ **F** (E+$1,500S $1,000/C)
Children						☐ **G** (E+$5,000S $2,500/C)
						☐ **H** (E+$10,000S $5,000/C)
						☐ **K** (E+$25,000S $10,000/C)
						☐ **L** (E+$10,000/C)
						☐ **M** (E+$50,000S $15,000/C)
						☐ **N** (E+$15,000/C)

I agree to the terms and conditions of this application and understand that I forfeit my rights to future eligibility if I do not enroll for at least one of my previous insurance coverages within my designated 60-day enrollment period.

Check only one box

☐ I wish to enroll as noted in Section II
☐ I do not wish to enroll

Applicant's Signature	Date

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IMPORTANT: TERMS AND CONDITIONS FOR CONTINUING YOUR INSURANCES

You must accurately and promptly complete this application, so the Employee Benefits Division (EBD) can verify continuation of requested insurances. You should return this form even if you do not wish to enroll in any insurance. Mail the completed application to the above address within 7 days, especially if you anticipate filing claims within the month. Waiting will delay notification to insurance plan administrators that process and pay insurance claims. If the form is not received in EBD by the due date in the upper-right corner, you will **not** be eligible to continue your insurances. Make and retain a copy of the form before mailing.

If you are eligible for LTD benefits, and you need health coverage, you must return this form requesting the health coverage. This will activate your LTD Rider to pay your premium, for up to six months, as long as you are receiving LTD benefits. Dental and vision premiums are **not** paid by the LTD Rider. If your spouse is a state employee or retiree, you may transfer your health, dental, and vision coverage to your spouse, within 31 days of losing the corresponding coverage.

Upon receipt of your application, EBD will process coverages you select. If you have enrolled in COBRA coverage (past the date of FMLA and/or LTD Rider benefits) you will receive a bill in the mail on a monthly basis. Continuation of your insurance benefits will depend on your timely, whole (not partial) premium payment by the due date shown on the billing invoices. COBRA Law provides a 45-day grace period from the date on the invoice for a full (not partial) premium payment. If your full payment is not received by the end of the grace period, your coverage(s) will be canceled for non-payment. Checks returned “Non-Sufficient Funds” (NSF) will cause the termination of your insurance benefits.

You must provide notice in writing, within 31 days, to EBD of any changes in your status or those of your family members which may affect eligibility and/or billing direction. Any falsification of these records may result in the cancellation of your insurance benefits.

The benefits you receive will be commensurate with active state employee/retirees. EBD may cancel your coverage for any of the following reasons (1) the State of Michigan no longer provides group health insurance coverage to any of its employees/retirees; (2) the premium for continuation coverage is not paid; (3) you become covered under another group health plan; or (4) you were divorced from a covered employee and subsequently remarry and are covered under your new spouse’s group health plan.

If you are in current paid-to-date status and have signed up for and have continued your Health, Dental, Vision and/or Life coverage, you may be eligible to participate in the annual State of Michigan open-enrollment process. If you have questions, please call 800-505-5011.

SPECIAL NOTE: If you are a former employee (not on a layoff or leave of absence), your family's COBRA eligibility can be extended from 18 months to 29 months if you were disabled upon your separation from State service or within the first 60 days of your COBRA continuation. Determination of disability must be through the Social Security Administration. To qualify for this extension, you must provide notification to the Employee Benefits Division within 60 days from the date the Social Security Administration issues the determination of disability and before the close of the 18-month coverage period.

DEPENDENT ELIGIBILITY

Your spouse and children may be covered under Health, Dental, and Vision plans if they meet the following eligibility criteria:

Spouse - your legal husband or wife may be covered as a dependent if the spouse is not also separately enrolled at the same time as an eligible State of Michigan Employee or Retiree or under their own COBRA coverage with the State of Michigan.

Children - your eligible children by birth, legal adoption or legal guardianship may be covered as a dependent if they are not also separately enrolled at the same time as an eligible dependent of another State of Michigan Employee or Retiree. Additionally, they may not be similarly enrolled on their own policy as an active State of Michigan Employee.

Enrolling Eligible Dependents - if you acquire any dependents after you are enrolled, you may enroll them within 31 days of the date they were newly acquired (date of marriage, birth, adoption, etc.) by contacting EBD.

No person (spouse or child) will be considered a “dependent” while serving in the armed forces of any country. In addition, no person may be covered both as a COBRA Enrollee and as a dependent, and no person may be covered as a dependent of more than one enrolled Employee or Retiree. Employees or Retirees or COBRA Enrollees who are married to each other may carry insurance coverages separately, but not with the same dependent children under both coverages.

This notice does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the plan administrator. This material is available in alternative formats, upon request. For further information, please call the EBD at 800-505-5011.