MICHIGAN OFFICE OF RETIREMENT SERVICES
Big Plans. Small Steps.
P.O. Box 30171 · Lansing, MI 48909-7671 www.michigan.gov/ors
Toll Free: 800-381-5111
Local: 517-284-4400
Fax: 517-284-4416

Insurance Enrollment/Change Request

For State Police Retirees

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN	PHONE NUMBER ( )
PHYSICAL ADDRESS (CANNOT BE A PO BOX)	COUNTY OF RESIDENCE	EMAIL ADDRESS
CITY, STATE, ZIP CODE		

Use this form to 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 other health, prescription drug, dental, or vision group insurance coverage, including Medicare if enrolling *before* age 65.

Section I: Enrolling In Insurances

Mark the appropriate boxes below for the insurance plan(s) in which you wish to enroll and who you want covered.

Please indicate the earliest effective date for your insurances to begin. 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 (see the instructions for more details).

Health Plan	**ENROLL** ☐	**Effective Date** /01/	**(Check all that apply)** ☐ SELF ☐ SPOUSE ☐ CHILD(REN)
IF ENROLLING IN A HEALTH PLAN, PLEASE CHOOSE ONE FROM THE FOLLOWING:			
☐ BCBSM WITH PRESCRIPTION DRUG PLAN ☐ BCBSM WITHOUT PRESCRIPTION DRUG PLAN	HMO (PRESCRIPTION DRUG PLAN INCLUDED): ☐ BCN ☐ HAP ☐ PRIORITY HEALTH ☐ PHYS HEALTH PLAN		
Dental Plan	**ENROLL** ☐	**Effective Date** /01/	**(Check all that apply)** ☐ SELF ☐ SPOUSE ☐ CHILD(REN)
Vision Plan	**ENROLL** ☐	**Effective Date** /01/	**(Check all that apply)** ☐ SELF ☐ SPOUSE ☐ CHILD(REN)

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. Copy the Medicare information from the Medicare card for anyone you are covering. Attach additional sheets if necessary.

ENROLLEE NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER		DATE OF EVENT:	RELATIONSHIP:	
MEDICARE INSURANCE COVERAGE? ☐ Y ☐ N (IF N, LEAVE THIS LINE BLANK)	MEDICARE NUMBER	MEDICARE, EFFECTIVE DATES PART A PART B		
OTHER INSURANCE COVERAGE? ☐ Y ☐ N (IF N, LEAVE THIS LINE BLANK)	POLICY #	CARRIER NAME/COVERAGE TYPE		

ENROLLEE NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER	DATE OF EVENT:	RELATIONSHIP:	

MEDICARE INSURANCE COVERAGE? ☐ Y ☐ N (IF N, LEAVE THIS LINE BLANK)	MEDICARE NUMBER	MEDICARE, EFFECTIVE DATES PART A PART B		
OTHER INSURANCE COVERAGE? ☐ Y ☐ N (IF N, LEAVE THIS LINE BLANK)	POLICY #	CARRIER NAME/COVERAGE TYPE		
ENROLLEE NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER		DATE OF EVENT:	RELATIONSHIP:	
MEDICARE INSURANCE COVERAGE? ☐ Y ☐ N (IF N, LEAVE THIS LINE BLANK)	MEDICARE NUMBER	MEDICARE, EFFECTIVE DATES PART A PART B		
OTHER INSURANCE COVERAGE? ☐ Y ☐ N (IF N, LEAVE THIS LINE BLANK)	POLICY #	CARRIER NAME/COVERAGE TYPE		

Dual Insurance Coverage

Is your spouse a participant of the State Employees Retirement system? ☐ **NO** ☐ **YES**
If YES, you and your spouse will be covered under a single contract. Please provide your spouse's social security number if not listed above. _____

Section II: Cancelling 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, and you do not have a name or address change, go to Section IV, sign the form and return it to ORS.

NAME (LAST, FIRST, MIDDLE)	MEDICARE NUMBER/SOCIAL SECURITY #
QUALIFYING EVENT: ☐ DEATH ☐ DIVORCE ☐ OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: ☐ HEALTH ☐ DENTAL ☐ DRUG ☐ VISION	RELATIONSHIP:

NAME (LAST, FIRST, MIDDLE)	MEDICARE NUMBER/SOCIAL SECURITY #
QUALIFYING EVENT: ☐ DEATH ☐ DIVORCE ☐ OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: ☐ HEALTH ☐ DENTAL ☐ DRUG ☐ VISION	RELATIONSHIP:

Section III: Name and/or Address Change

If you have a name or address change, indicate that change below. For name change, provide legal documentation such as a copy of a marriage certificate, divorce decree, court order, or a replacement social security card. Then sign Section IV.

NEW LAST NAME	FIRST NAME	MIDDLE INITIAL

PHYSICAL ADDRESS (CANNOT BE A PO BOX)	APT OR SUITE
CITY, STATE, ZIP CODE	COUNTY OF RESIDENCE

MAILING ADDRESS ☐ (CHECK IF SAME AS PHYSICAL AND LEAVE BLANK)	APT OR SUITE
CITY, STATE, ZIP CODE	

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

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

Insurance Enrollment/Change Request Instructions

Enrolling In or Changing Insurance After Retirement

Use this form to enroll in one or more of the retirement system insurance plans, change from one health plan to another, or update Medicare of dependent coverage. Prescription drug insurance is part of your Health Maintenance Organization (HMO) coverage. You can enroll in Blue Cross Blue Shield of Michigan (BCBSM) with prescription drug coverage or without.

Effective Dates. If you have the premium subsidy benefit and enroll after your retirement effective date, your insurance effective date will be six months after we receive your enrollment request and all required proofs unless you have a qualifying event. For example, if we get your request and proofs on February 10, your coverage would start August 1.

If you or a dependent have a qualifying event and ORS gets the request and proofs within 30 days of the qualifying event, coverage can begin sooner. For retirees who do not have Medicare, coverage can begin the first day of the month after we receive your request and any required proofs, including proof 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 on 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 your request and any required proofs are received. For example, if ORS receives your change request and any required proofs on January 10, your coverage with the new plan will begin on 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. If you enrolled in insurances before your subsidy effective date and are paying the entire premium, ORS will automatically reduce your premium on your subsidy effective date.

Self and Dependent Coverage: Eligibility and Proofs

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

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 comes first, if he or she is:

- Unmarried and between the ages of 19 and 26.
- Dependent on you for at least 50% of financial support.
- Enrolled at least half-time in an accredited educational institution.

Proofs. Provide your marriage certificate if married and spouse's and dependents' 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 enrolled dependent is a disabled child, coverage will continue as long as he or she was totally and permanently disabled before age 19, continues to be disabled, and your coverage does not terminate for any other reason. Provide a current letter from the attending physician stating the child is totally and permanently disabled and incapable of self-sustaining employment and detailing the disability, and the IRS form 1040 that identifies the child as your dependent. In some cases we may ask for additional information to determine medical eligibility, which may delay enrollment. You may also be asked to furnish proof of disability and dependency each year.

Insurance Enrollment/Change Request Instructions

Qualifying Events

The following are considered qualifying events for adding a dependent. You must submit proofs with the application within 30 days of the qualifying event. **Photocopies are acceptable.**

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

Involuntary loss of coverage in another group plan: Provide a statement on letterhead from the terminating group insurance plan explaining who was covered, what 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 birth certificate.
Death: Acceptable proof is original death certificate.
Divorce: For enrollment, provide a statement on letterhead from the terminating group insurance plan explaining who was covered, what type of coverage it was, why coverage is ending, and the date coverage ends.
Marriage: Acceptable proof is a marriage certificate.

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 promptly** of any changes in your status or that of your family 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 re-enroll.

For most people, Medicare begins at age 65 or after 24 months of social security disability. If that happens before age 65, send ORS this form, and make sure ORS has your Medicare number.

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

ORS cannot enroll you retroactively in the state health plan once you're eligible for Medicare**.**

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.

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.