MICHIGAN OFFICE OF RETIREMENT SERVICES
P.O. Box 30171 · Lansing, MI 48909-7671 www.michigan.gov/ors 800-381-5111
517-322-5103

Insurance Enrollment/Change Request – *Public School Retirees*

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

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 insurance coverage, including Medicare if enrolling before age 65.

Section I: Enrolling In Insurance

Check the box for the provider you are selecting. You can choose either Blue Cross Blue Shield of Michigan (BCBSM), with or without OptumRx prescription drug coverage, or a Health Maintenance Organization (HMO), which includes drug coverage. Also check the box for dental/vision if you wish to add that insurance. Please indicate the *earliest* effective date for your insurance plans to begin. Effective dates are always the first of the month. ORS will determine your actual insurance effective date based on your qualifications.

Health Plan	**ENROLL** ☐	**Effective Date** /01/	**(Check all that apply)** ☐ SELF ☐ SPOUSE ☐ CHILD(REN) ☐ PARENT(S)
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 ☐ PRIORITY HEALTH	

Dental/Vision Plan	**ENROLL** ☐	**Effective Date** /01/	**(Check all that apply)** ☐ SELF ☐ SPOUSE ☐ CHILD(REN) ☐ PARENT(S)

Complete the following information about yourself and dependents you wish to enroll. Provide proofs for any new dependents you are adding. 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, 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		

Department of Technology, Management & Budget
R0452C (Rev. 4/2018) Authority: 1980 P.A. 300, as amended

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		

Section II: Canceling Insurance

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 change or address change, go to Section IV, sign the form and return it to ORS.

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

NAME (LAST, FIRST, MIDDLE)				MEDICARE #/SOCIAL SECURITY #
QUALIFYING EVENT:	☐ DEATH	☐ DIVORCE	☐ OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED:	☐ HEALTH	☐ DENTAL	☐ 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 affirm that I have read and understand the Conditions of Enrollment specified in this form's instructions, including, if applicable, the sections pertaining to Medicare.

PENSION RECIPIENT/CONTRACT HOLDER SIGNATURE	DATE

Return your completed form to: ORS, P.O. Box 30171, Lansing, MI 48909-7671, or Fax: 517-322-1116.

Insurance Enrollment/Change Request Instructions

Enrolling In or Changing Insurance After Retirement

Delayed Subsidy. If you were subject to a delayed subsidy at retirement and wish to have your enrollment coincide with your subsidy eligibility date, you must submit this form at least six months before that date.

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 of the month after we receive your completed application and proofs. For retirees with Medicare, your 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 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. If he or she is an eligible public school retiree, you will be covered under one contract.
- Your unmarried child by birth or legal adoption, through December 31 of the year in which he or she turns age 19.
- Your unmarried child by legal guardianship until age 18.
- Your unmarried child by birth or legal adoption from age 19 through December 31 of the year in which he or she reaches age 25, if a full-time student and dependent on you for support.
- Your unmarried child by birth or legal adoption age 19 or older who is totally and permanently disabled, dependent on you for support, and incapable of self-sustaining employment.
- Either your parent(s) or your parent(s)-in-law residing in your household—one set of parents, not both.

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.

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.

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.

Once you sign up for Medicare, we will enroll you in a Medicare Advantage plan. A Medicare Advantage plan is a private health plan that coordinates with Medicare and supplements Medicare coverage

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.

ORS cannot enroll you retroactively in insurances plan once you're eligible for Medicare**.**