MICHIGAN OFFICE OF RETIREMENT SERVICES
PO Box 30171 · Lansing, MI 48909-7671 Michigan.gov/ORS Toll Free: 800-381-5111 Fax: 517-284-4416

Opt-In Form – For Medicare-Eligible State Police Troopers and Sergeants Retired on or After October 1, 1987

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN
MAILING ADDRESS	DAYTIME TELEPHONE
CITY, STATE, ZIP CODE	
EMAIL ADDRESS	

There are three State Health Plan PPO options available for Medicare-eligible members. When you become eligible for Medicare, the Michigan Office of Retirement Services (ORS) will not automatically enroll you in a Medicare plan. If you want to enroll in a Medicare plan, you need to opt in to the plan by submitting this form and required documents to ORS. **If you don't opt in, you will stay enrolled in the commercial plan.** If you have Medicare and tell ORS your Medicare information but you don't opt in to the Medicare Advantage Plan, you will default to the Medicare Supplement Plan. *The only way you can opt in to the Medicare Advantage Plan is to submit this form and required documents to ORS.*

MEMBER'S NAME	**BIRTHDATE**
SOCIAL SECURITY NUMBER	**MEDICARE NUMBER**
MEDICARE PART A EFFECTIVE DATE	**MEDICARE PART B EFFECTIVE DATE**

Indicate your enrollment choice by checking the box next to the plan you're selecting. All State Health Plan PPO options have the same plan design, deductibles, copays, out-of-pocket costs, and Optum Rx prescription drug plan.

☐ **Option 1:** I want to enroll in the **Medicare Supplement Plan**.
The Medicare Supplement Plan is Original Medicare. It pays claims as primary, and the State Health Plan PPO pays claims as secondary. You will present both cards when getting medical services. You must provide proof of enrollment in Medicare parts A and B to ORS; you may be eligible for a reduction in your monthly premium.

☐ **Option 2:** I want to enroll in the **Medicare Advantage Plan**.
The Medicare Advantage Plan includes a variety of other programs at no cost to you, including Silver Sneakers, Livongo, and other options designed to improve health. You will present only the Medicare Advantage card for nearly all services. You must provide proof of enrollment in Medicare parts A and B to ORS; you may be eligible for a reduced monthly premium.

☐ **Option 3:** I want to continue in the **Commercial (non-Medicare) Plan**.
You will remain in this plan until you give ORS your Medicare number and Part A and Part B effective dates. There will be no reduction in your monthly premium. If ORS receives your Medicare information and you don't opt in to the Medicare Advantage Plan, you will default to the Medicare Supplement Plan.

By my signature below, I certify that the above information is correct to the best of my knowledge and belief and that I agree to the following conditions of enrollment:

- *By enrolling in the insurance plans, I understand that my family members and I are bound by all conditions stated in the plan.*
- *I agree to notify ORS of any changes in my status and that of my family that may affect eligibility and/or coverage.*
- *I agree that if claims are paid on an ineligible individual, the cost of such claims may be deducted from future supplemental benefit payments.*

I authorize the administrator selected by ORS to obtain from providers of service any and all records and other information relating to me and my covered family members.

MEMBER'S SIGNATURE	**DATE**
DAYTIME PHONE NUMBER, INCLUDING AREA CODE	

AUTHORIZED REPRESENTATIVE — SIGN AND COMPLETE THE SECTION BELOW	
I am authorized to act on behalf of the individual above under the laws of the state where the individual resides. My signature certifies that: (1) I am authorized under state law to complete this form, and (2) documentation of this authority is available upon request.	
REPRESENTATIVE'S SIGNATURE	**DATE**
PRINTED NAME OF REPRESENTATIVE	**REPRESENTATIVE'S CITY, STATE, ZIP CODE**
DAYTIME PHONE NUMBER, INCLUDING AREA CODE	**RELATIONSHIP TO MEMBER**

Physical Address

The Centers for Medicare and Medicaid Services requires a physical address when enrolling in insurance coverage with ORS. Provide your physical address, including the county of your residence. You cannot be enrolled in insurance with a post office (PO) box or private mailbox. This form was mailed to the mailing address we have on file. If your physical address is different from your mailing address, or if you use a PO box or private mailbox, please provide your physical address below.

PHYSICAL ADDRESS (CANNOT BE A PO BOX OR PRIVATE MAILBOX)		COUNTY
CITY, STATE, ZIP CODE		

Race and Ethnicity *(Optional)*

Provide the following information for anyone you're enrolling on your insurance. The Centers for Medicare and Medicaid Services requires ORS to ask about race and ethnicity. Answering these questions is optional. You can't be denied coverage because of your responses or if you don't complete this section.

RACE	SELECT ALL THAT APPLY			ETHNICITY	SELECT ALL THAT APPLY		
	Self	Spouse	Child		Self	Spouse	Child
White				Not of Hispanic, Latino/a, or Spanish origin			
Black or African American				Puerto Rican			
American Indian or Alaska Native				Another Hispanic, Latino/a, or Spanish origin			
Asian Indian				Mexican, Mexican American, Chicano/a			
Chinese				Cuban Puerto Rican			
Filipino				**I choose not to answer**			
Japanese							
Korean							
Vietnamese							
Other Asian							
Native Hawaiian							
Samoan							
Guamanian or Chamorro							
Other Pacific Islander							
I choose not to answer							

Mail your completed form to: Michigan Office of Retirement Services P.O. Box 30171 Lansing, MI 48909-7671 **Or fax to:** 517-284-4416