

EASTERN MICHIGAN UNIVERSITY
Benefits Enrollment/Change Form
Please print all information clearly.

Department Use Only:
 Medical Group: 81205-_____ Transfer to _____
 Eff. Date: _____
 Service Code: _____ - _____ - _____
 Dental Group: 1873-_____ Transfer to _____
 Eff. Date: _____

Faculty/Staff Information

Name (Last, First, Middle Initial)		Employee ID	SS#	Work Phone
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	Email Address: _____@emich.edu		Home Phone
Address _____ New? <input type="checkbox"/> Yes <input type="checkbox"/> No		City	State	Zip _____ Date of Birth

Date of Event: _____ **NOTE:** This form must be received by the Benefits Office **within 30 days** of the event.

Enroll/Add/Change <input type="checkbox"/> Enroll/New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Additional Eligible Adult <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Principal Support <input type="checkbox"/> Other: _____	Delete <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent <input type="checkbox"/> Death <input type="checkbox"/> Termination <input type="checkbox"/> Other: _____	Cancel <input type="checkbox"/> Cancel coverage for me and my dependents. Reason: _____ _____
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Medical (CP, CS, LE, PS only) <input type="checkbox"/> BCBSM Option 1 <input type="checkbox"/> BCBSM Option 2 <input type="checkbox"/> Waive Medical Coverage – Documentation Attached	Medical (AC, AH, AP, CC, FA, FM, PT, VF only) <input type="checkbox"/> BCBSM Option 3 <input type="checkbox"/> BCBSM Option 4 <input type="checkbox"/> Waive Medical Coverage – Documentation Attached	Dental <input type="checkbox"/> Delta Dental
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***Medicaid or Medicare** – Are any of your dependents listed above eligible for Medicaid or Medicare? Yes No If Yes, attach a copy of the Medicaid or Medicare card.

***Insurance Information other than Medicare** – Are you or anyone named on this application covered by health insurance from another source?
 Yes No If Yes, complete below:

Name of Policy Holder	Name of Employer	Group Number

Dependent Information - You must complete the following section for all additions and/or deletions. Enter the information for each dependent, and then write **A** in the appropriate benefit column to add to your coverage or **D** to delete from your coverage, or **C** to change.

Name (Last, First, Middle Initial)	Social Security Number	Relationship Code ¹	Gender (M/F)	Date of Birth MM/DD/YY	Medical	Dental	*Other Insurance
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

¹Relationship Code - SP = Spouse; D = Dependent; DD = Disabled Dependent; AEA = Additional Eligible Adult; SD = Sponsored Dependent Rider
Coverage for dependents is only allowed when certain criteria are met. Proof of eligibility may be required.

Certification and Signature – I have read and agree to the terms and conditions listed on the back of this form. The information provided above is correct to the best of my knowledge.

 Signature of Faculty or Staff Member

 Date Signed

INSTRUCTIONS

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. **PLEASE PRINT CLEARLY.** If you have any questions about filling out this form, please contact the Benefits Office, 140 McKenny Hall, Ypsilanti, MI 48197 734.487.3195

Request for Changes in Membership – Adding Members to Contract (Additions)

Marriage	Report addition of wife/husband within 30 days of event. May sign 30 days before marriage. Proof of marriage is required.
Birth	Report within 30 days of date of birth. Proof of birth is required.
Stepchild	Report within 30 days of marriage. May sign 30 days before marriage.
Child by Legal Adoption	Report within 30 days of date of placement. Placement occurs when the subscriber becomes legally obligated for total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.
Child by Legal Guardianship (ward)	Same as legal adoption.
Child for whom subscriber pays principal share of support	Do not confuse with support of stepchildren. Use this for a relative, such as a dependent grandchild, nephew, etc. Give date support began. The child's effective date will be no earlier than 90 days after support for 6 months has been established.
Sponsored Dependent Rider	<ol style="list-style-type: none"> 1. Dependent is over 19 years of age. 2. Dependent is not eligible for coverage as a Family Continuation Rider member. 3. Subscriber provides more than half of the support for the dependent. 4. Dependent is related to the subscriber by blood, marriage, or legal adoption. 5. Dependent is a member of the subscriber's household.
Disabled Dependent (Public Act 275)	Unmarried children, incapable of self-sustaining employment because of a disability prior to age 19. You must supply proof of the disability from the physician licensed in Michigan.
Court Ordered Coverage	If you have a court order requiring you to provide coverage for a child. Copy of court order to verify eligibility. A court order includes a court approved settlement agreement.

Removing Members from Contract (Deletions)

Death of Dependent	Give name of deceased dependent, Social Security number and date of birth.
Divorce	Give name of divorced spouse and date of divorce. Give Social Security number and address of divorced spouse.
Marriage of Minor or Dependent	Give the date of marriage and (new) name of former dependent. Give Social Security number and address of former dependent.
Transfer Information	Eligible dependents covered through another insurance may transfer to your group plan, but only due to loss of coverage. Termination date must be supplied. Transfer must be made 30 days from date of termination.

Other

Death of Subscriber	Give the date of subscriber's death.
Termination of Subscriber	Give date that subscriber's coverage ends due to termination of employment.
Change of Name	Give the new name. Former name should be entered in parentheses (.). Proof of name change required.