EASTERN MICHIGAN UNIVERSITY

# Benefits Enrollment/Change Form

*Benefits Dept. Use Only:*
*Medical: PPO 007003673-_____ HMO 00116292-_____*
*Eff. Date: _____ Transfer to _____*
*Service Code: _____*
*Dental Group: 1873-_____ Transfer to _____*
*Eff. Date: _____*

***Please print all information clearly.***

## Faculty/Staff Information

☐ AC ☐ AH ☐ AP ☐ CA ☐ CP ☐ CS ☐ FA ☐ FM ☐ LE ☐ PE / PT ☐ PS ☐ VF

| Name (Last, First, Middle Initial) | | Employee ID | SS# | | Work Phone |
|---|---|---|---|---|---|
| ☐ Male ☐ Female | ☐ Single ☐ Married | Email Address: @emich.edu | | | Home Phone |
| Address New? ☐ Yes ☐ No | | City | State | Zip | Date of Birth |

## Medical and Dental elections for OPEN ENROLLMENT 2017

**Please take this opportunity to review your health and dental plan elections. You may change plans, add or delete dependents. Please return your completed form to the Benefits Office. Changes become effective January 1, 2017.**

**MEDICAL**
- ☐ **PPO Option 5**
- ☐ **Simply Blue HSA (High Deductible PPO): submit HSA enrollment form**
- ☐ **HMO**
- ☐ **Waive Medical Coverage: submit waiver of coverage form**

**DENTAL**
- ☐ **Delta Dental**

***Medicaid or Medicare** – Are any of your dependents listed below 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 medical/dental benefit columns to Add to your coverage or **D** to Delete from your coverage.
**Attention AP, AH, CA, AC, LE, FA, FM and CP employees** - Spouses with access to subsidized employer coverage must enroll in his/her employer coverage prior to enrolling in EMU's plan (secondary coverage only). If covering your spouse, submit the Health Plan Affidavit for Spouses.

| Name (Last, First, Middle Initial) | Social Security Number | Relationship Code[1] | Gender (M/F) | Date of Birth MM/DD/YY | Medical | Dental | *Other Insurance |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |

[1]Relationship Code - **SP** = Spouse; **D** = Dependent; **DD** = Disabled Dependent; **AEA** = Additional Eligible Adult; **SD** = Sponsored Dependent Rider

**Marriage Certificate and Federal Tax Return is required to cover your spouse. Birth Certificates are required to cover dependents. Coverage for dependents is only allowed when certain criteria are met. Other proof of eligibility may be required.**

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

_____ _____
Signature of Faculty or Staff Member Date Signed