



Office of Retirement Services

P.O. Box 30171 | (800) 381-5111 (Lansing area 322-5103)
Lansing MI 48909-7671 | www.michigan.gov/ors

OFFICE USE ONLY
RETIREE EFFECTIVE DATE
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Group Insurance Application — Health, Vision, and Dental

PRINT AND COMPLETE ALL SPACES AS APPROPRIATE.

A. PENSION RECIPIENT DATA (This Section Must Be Completed)
SOCIAL SECURITY NUMBER
PLAN ADMINISTRATOR'S USE ONLY
NAME LAST FIRST MIDDLE BIRTHDATE
ADDRESS CITY STATE ZIP CODE PHONE
ARE YOU ENROLLED IN MEDICARE? MEDICARE NO. EFFECTIVE DATES FROM MEDICARE CARD

B. COVERAGE DATA (This Section Must Be Completed)
STATE HEALTH PLAN - BCBSM/PPO ENROLL DECLINE
OTHER ENROLL DECLINE PLEASE OBTAIN AND ENCLOSE COMPLETED HMO APPLICATION
STATE VISION PLAN ENROLL DECLINE
STATE DENTAL PLAN ENROLL DECLINE

C. DEPENDENT DATA (Family Members You Are Covering)
LIST DEPENDENTS TO BE COVERED FOR THE INSURANCES CHECKED IN SECTION B. ATTACH ADDITIONAL PAGES IF NECESSARY.
If you are enrolling a child age 19 or older you must provide proof of age, dependency, and school attendance (or incapacity if applicable) with this application.
SPOUSE: NAME (Last, First, Middle) MEDICARE/SOCIAL SECURITY NUMBER EFFECTIVE DATE FROM MEDICARE CARD SEX BIRTHDATE
CHILD: NAME (Last, First, Middle) MEDICARE/SOCIAL SECURITY NUMBER EFFECTIVE DATE FROM MEDICARE CARD SEX BIRTHDATE

D. OTHER INSURANCE DATA (Complete When You Or Dependents Are Covered By Other Health Insurance)
ATTACH ADDITIONAL PAGES IF NECESSARY.
NAME OF HEALTH INSURANCE COMPANY POLICY HOLDER'S NAME POLICY NUMBER WHO IS COVERED?
NAME OF VISION INSURANCE COMPANY POLICY HOLDER'S NAME POLICY NUMBER WHO IS COVERED?
NAME OF DENTAL INSURANCE COMPANY POLICY HOLDER'S NAME POLICY NUMBER WHO IS COVERED?

I have read and agree to the applicable terms and conditions of this application as stated on the reverse side.
PENSION RECIPIENT'S SIGNATURE DATE

Send your completed form with necessary proofs to:
Office of Retirement Services, P.O. Box 30171, Lansing, MI 48909-7671
Retain a copy of this form for your records.

1) Enrollment

You must decide within 31 days after your pension effective date whether you will enroll in the insurance plans. If you choose not to enroll then, you may enroll later. If you enroll later, your coverage will begin six months following the first day of the month in which the Office of Retirement Services (ORS) receives your completed insurance application. For Blue Cross Blue Shield of Michigan/PPO, state vision plan and state dental plan insurance applications, call or write ORS. To enroll in any of the available HMOs, contact the appropriate HMO directly for an application to complete and return to ORS with your retirement application.

The six-month waiting period can be waived if you enroll in this plan because you or your dependents lose eligibility for coverage in another group plan. Coverage can begin within 31 days after ORS receives your completed application along with a letter from the other group plan stating date of loss of coverage, why you are losing coverage and who was covered by the plan. You must notify ORS within 31 days of the loss of coverage to avoid the six-month waiting period.

2) Effective Date of Coverage

Medical, vision, and dental coverage always begins the first day of a calendar month. If you are a new retiree, you can begin coverage on the pension effective date or up to 90 days later. An approved application must be on file prior to the first of the month in which coverage is to begin.

Determining the correct effective date is very important and is your responsibility. ORS cannot provide premium refunds.

3) Coordination of Benefits (COB)

If both you and your spouse are state retirees and are enrolled in the same group plan, there will be no advantage for duplicating coverage because COB will not apply. You cannot cover your spouse if he or she is separately enrolled at the same time as an eligible state employee or state retiree.

4) Medicare

At age 65 or sooner if eligible (because of disability), you must enroll in Medicare health insurance (both hospital – Part A, and medical – Part B) through the Social Security Administration to maintain full benefit coverage. A copy of your Medicare card must be submitted to ORS.

5) Coverage for Your Dependents

Eligible dependents for health, dental, and vision insurance plans include your spouse (as long as he or she is not also separately enrolled as an eligible state employee or retiree) and your unmarried children until the end of the month in which they turn 19. Coverage for your eligible dependents will be the same as yours. You may be asked to provide tax returns as proof of dependency and school records as proof of school attendance.

In addition to being unmarried, children must meet the following conditions to be eligible. They must be:

- Your children by birth, legal adoption or legal guardianship who are in your custody and dependent on you for support.
- Your children by birth, legal adoption or legal guardianship who do not reside with you, but are your legal responsibility for the provision of medical care (for example, children of divorced parents).

In the case of 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. A sworn statement with the date of placement or a court order verifying placement is required.

6) By Signing the Front of This Form, I Agree to the Following Terms and Conditions:

I elect to enroll in the insurance plan(s) funded by the State Employees' Retirement System for which I am or may become eligible, as indicated on the front side of this application, and authorize ORS to withhold the premiums required for the plan(s).

I agree that it is my responsibility to notify ORS of any changes in my status and that of my family that affects eligibility and/or coverage. I agree that should claims be paid on an ineligible individual, the costs of such claims may be deducted from future pension checks.

I authorize the administrator(s) identified by ORS to obtain from providers of service any and all records and other information relating to my covered family members and me. I understand that such information may be made available to ORS, on a confidential basis, for the purpose of evaluating the operation and efficiency of the plan(s) and providers. The duration of this authorization extends for the period of my coverage under the plan(s).

I certify that the information provided on the front side of this form is correct to the best of my information, knowledge, and belief.

I understand that when ORS accepts my application, my family members and I are bound by all conditions stated in the plan(s).

If I have declined coverage on the front of this form, I understand that I have been offered enrollment in the above plan but decline coverage at this time.

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