

NOTIFICATION BY EMPLOYEE/RETIREE OF QUALIFYING EVENT

INSTRUCTIONS: This form is used to notify the State of Michigan of a qualifying event and the name(s) and address(es) of family members who will be removed from insurance coverage. Make and retain a copy for your records. Employees should return the completed form to their Human Resources Office/MI HR Service Center. Retirees should return the completed form to State Employees Retirement System, P.O. Box 30171, Lansing, MI 48909. If this form is returned in a timely manner, the information will be used to notify the family members of their rights to continue insurance coverages. Please complete the top portion of this form and either Section I if you are recently divorced, or Section II if you have a dependent child no longer eligible. A portion of this information is protected by federal privacy laws and/or state confidentiality requirements.

PRINT OR TYPE

NAME OF EMPLOYEE/RETIREE (Last, First, MI)				SOCIAL SECURITY NO OF EMPLOYEE/RETIREE	
ADDRESS OF EMPLOYEE/RETIREE (City, State, Zip)				EMPLOYEE ID NUMBER	
I hereby notify the State of Michigan that the following event has occurred: <input type="checkbox"/> Divorce – Complete Section I <input type="checkbox"/> Dependent Child No Longer Eligible – Complete Section II					
SIGNATURE OF EMPLOYEE/RETIREE				DATE (MM/DD/YYYY)	
SECTION I – DIVORCE (Include copy of Judgment of Divorce)					
NAME OF SPOUSE				SOCIAL SECURITY NUMBER	
ADDRESS				DATE OF DIVORCE (MM/DD/YYYY)	
CITY	STATE	ZIP CODE	WORK PHONE	HOME PHONE	
Name(s) of Dependent Child(ren) being removed from coverage					
LAST	FIRST	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NO		
SECTION II – DEPENDENT CHILD NO LONGER ELIGIBLE					
NAME OF CHILD				DATE INELIGIBLE (MM/DD/YYYY)	SOCIAL SECURITY NO
ADDRESS				REASON INELIGIBLE	
CITY	STATE	ZIP CODE	WORK PHONE	HOME PHONE	

IMPORTANT NOTE: THIS FORM MUST BE RETURNED WITHIN 60 DAYS OF THE DATE OF THE EVENT