

**Health Enrollment/Change Form** (If opting out of all insurance options- skip to OPT OUT section)

DO NOT EMAIL THIS FORM. Send via fax to 487-3220 or campus mail to Benefit Services

Employee Name (Last, First, Middle Initial)	Social Security Number	Date of Birth	Date of Hire (new employee)
Street Address, Apt #	City	State	Zip

Single  
  Married  
  Male  
  Female  
  Name Change \_\_\_\_\_ Phone # \_\_\_\_\_

**Date of Event:** \_\_\_\_\_ This form must be received by the Benefits Office **within 30 days** of the event.  
 (date of hire or date of change)

**Benefit:** HuskyCare Medical  
 HDHP 1  
 HDHP 2  
 PPO  
 Dental 1  
 Dental 2  
 Vision

**Enroll in Coverage**

Enroll - new hire  
 Enroll - benefit eligible  
 Enroll - self or dependent - loss of coverage\*  
 Enroll - spouse (marriage/arrival into U.S.)  
 Enroll - child (birth/adoption/other\*): \_\_\_\_\_  
 Enroll - Designated Eligible Individual \*  
 Enroll - Flexible Spending Account\*  
 Enroll - Switching to Michigan Tech Primary\*

\*Reason: \_\_\_\_\_

**Cancel Coverage**

Cancel – divorce\*\* (Provide address below)  
 Cancel – death\*\*  
 Cancel – dependent access to other coverage\*\*  
 Cancel – age 26\*\* (Provide address below)  
 Cancel coverage for me\* \*\*  
 Cancel coverage for me and my dependents\* \*\*  
 Cancel Flexible Spending Account\*

\*Reason: \_\_\_\_\_  
 Address of dependent losing coverage (If different than above): \_\_\_\_\_

*Employee may need to provide legal document with reason for change and provide dependent verification*

**You must complete the following section for all additions or deletions**

Dependent Name as listed on Social Security card	SSN (required) or check if H-4 visa <input type="checkbox"/>	Relationship	Date of Birth	Gender M / F

List additional dependents on reverse

**Flexible Spending Enrollment – Family Status Change Only**  
 Enroll  
 Change  
 Terminate

FSA - Healthcare  
 FSA Dependent Care  
 Per Paycheck (bi-monthly) \$ \_\_\_\_\_ Annual Election \$ \_\_\_\_\_

**OPT OUT Section:**

I am opting out of health, dental and vision my coverage is with: \_\_\_\_\_

I hereby certify that all of the above information is true and correct. I understand that group coverage will not be effective until all eligibility documents have been verified and questions regarding eligibility for coverage have been satisfactorily resolved by the plan sponsor.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Benefits Office Use:  
 PDAEDN  
 PDABENE  
 PEAREVW (RO & RV)  
 PDABCOV  
 Health  
 HSA  
 Dental  
 Vision
- ACA Reportable Child  
 BCBSM Healthy Blue  
 Express Scripts  
 Fidelity  
 Dependent Docs  
 Audit  
 \*\* Send COBRA