



Designated Eligible Individual (DEI) Enrollment Form

A Michigan Tech employee, who does not enroll a spouse for health coverage, may enroll one individual as a Designated Eligible Individual (DEI), if all of the following DEI eligibility criteria are met:

- The employee is eligible for Michigan Tech's health plan options.
- The DEI, at the time of proposed enrollment, resides in the same residence as the employee and has done so for the previous 18 months, other than a tenant.
- The DEI is not a dependent of the employee as defined by the IRS.

Children who are qualified and claimed as IRS-defined dependents by an employee's DEI are also eligible if they are members of the employee's household or an enrolled student and if they are unmarried, up to age 26.

Eligibility to continue coverage for a DEI or a dependent of a DEI ceases at the end of the month in which the above criteria are not met. Employees must immediately notify the Michigan Tech Benefits office of a change in eligibility status.

The following individuals do not fall within the eligibility criteria:

- Spouse
- Parents' descendants (siblings, nieces, nephews)
- Parents
- Grandparents and their descendants (aunts, uncles, cousins)
- Children and their descendants (grandchildren)
- Renters, boarders, tenants

This program does not affect the rights of or criteria applicable to any employee qualifying for enrollment in Michigan Tech's health plans under any other applicable University policy.

DEI enrollment can be completed during the annual Benefits Services open-enrollment period or within 30 days of meeting the DEI eligibility criteria. Required documentation to verify eligibility is required.

Please submit completed forms to Benefits Services via sealed mail or fax to (906)487-3220. Please do not email the form as it is not a secure method of submission for the information being collected.

DEI Enrollment Information					
Name (Last, First, MI)	SSN	Date of Birth	Gender (M/F)	Relationship	Enrollment Type (Medical, Dental, and/or Vision)
				DEI	
				Child of DEI	
				Child of DEI	
				Child of DEI	

I understand that any information falsified may result in discipline up to and including termination from employment. I certify that the person named above meets all of the DEI eligibility criteria as stated above. I understand that I will be responsible for paying taxes associated with enrolling a DEI.

Employee Name _____ M# _____

Employee Signature _____ Date _____

Benefit Services Use Only

PDAEDN
 PDABENE
 PDABCOV
 Medical
 RX
 Dental
 Vision
 DEI Documentation
 DEI Binder