Michigan Technological University

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 ☐	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: ☐ PDADEDN ☐ PDABENE ☐ PEAREVW (RO & RV) ☐ PDABCOV ☐ Health ☐ HSA ☐ Dental ☐ Vision

☐ ACA Reportable Child ☐ BCBSM Healthy Blue ☐ Express Scripts ☐ Fidelity ☐ Dependent Docs ☐ Audit ** Send COBRA