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.

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

<table>
<thead>
<tr>
<th>Dependent Name</th>
<th>SSN (required)</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Gender M / F</th>
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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

12/03/2018