

Michigan State University  
**Human Resources Benefits**  
1407 S Harrison Road, Suite 140A  
East Lansing MI 48823-5287



## Enrollment Request Due to Loss of Previous Coverage

Health Plan

Dental Plan

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last, First MI

### Previous Coverage Information

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last, First MI

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street Address City State Zip Code

Name of Former Group Health Carrier: \_\_\_\_\_

Identification Numbers: \_\_\_\_\_ Termination Date: \_\_\_\_\_  
Group # Contract #

Reason for Coverage Termination: \_\_\_\_\_

Name of Former Group Dental Carrier: \_\_\_\_\_

Identification Numbers: \_\_\_\_\_ Termination Date: \_\_\_\_\_  
Group # Contract #

Reason for Coverage Termination: \_\_\_\_\_

1. Applicant must apply for transfer into an MSU group health and/or dental plan within 31 days of involuntary termination (such as death, divorce, terminated employment, etc.) from the former group health and/or dental plan.
2. The former group health and/or dental plan must be independent of any program now co-existing in this group.
3. All applicants must be eligible for coverage as an employee of this group.
4. The applicant is entitled to all benefits under the group plan.
5. Coverage will become effective on the date of enrollment in MSU's group health and/or dental plan or termination from the previous group health and/or dental plan, whichever is later.

**Please attach a copy of the previous health and/or dental plan identification card.**

I have read and understood the above information. I hereby certify that the information supplied by me is true and request coverage for my family and myself in the health and/or dental plan sponsored by my employer.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

*MSU is an affirmative-action equal-opportunity institution.*