Michigan State University
**Human Resources**
1407 S Harrison Road, Suite 110A
East Lansing MI 48823-5287

# Enrollment Request
# Due to Loss of Previous Coverage

☐ Health Plan ☐ Dental Plan

Employee Name: _____ Last 4 digits of SSN: _____
Last, First MI

**Previous Coverage Information**

Insured's Name: _____ Last 4 digits of 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**

-- Due to the sensitive nature of information on this document, please do not email. --

*MSU is an affirmative-action equal-opportunity employer*