



Complete this form to enroll in, change, or cancel benefits for you, your eligible spouse/other eligible individual (OEI), or dependent(s).

- Do NOT complete this form if you completed enrollment online at www.ebs.msu.edu.
- Please only use this form if you are enrolling or making changes to your existing plan(s) and only fill out the sections you're making changes to. If you are not making any changes, you do not need to fill out this form.
- If you have a qualifying life event (QLE), forms must be received by MSU Human Resources no later than **30 days** after the event.
- Enrollment in voluntary benefits is completed with the benefit vendor directly:
 - ARAG Legal Insurance - 800-247-4184 OR www.araglegal.com/myinfo (access code: 17873ret)
 - VSP Vision Insurance - 800-400-4569 OR www.msuretirees.vspforme.com
- **If you are enrolled in another Medicare plan, you will be automatically disenrolled from that plan if you enroll in the MSU Medicare Advantage Plan.**
- For more information regarding enrollment and qualifying life events, please contact MSU Human Resources at SolutionsCenter@hr.msu.edu or 517-353-4434 (toll-free: 800-353-4434).

Personal Information – Please Print Clearly

Retiree OR Surviving Spouse Name (Last, First, Middle Initial)		Social Security Number ¹ (last 4 digits) or ZPID	
Home Street Address		Home City	Home State
		Home Zip Code	
Home/Cell Phone	Email	Retiree Medicare Beneficiary Identifier (MBI) ¹ – 11-digit number	
If your spouse/OEI is an MSU employee/retiree, indicate their full name			

Reason for Completing this Form (please choose one)		Event Date (Required)	
<input type="checkbox"/> Benefit Exception	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Dependent Arrival in the US	<input type="checkbox"/> Divorce
<input type="checkbox"/> Loss of Previous Coverage (LOPC)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Medicare Eligibility	<input type="checkbox"/> Newly Eligible
<input type="checkbox"/> Obtaining Other Coverage	<input type="checkbox"/> Retirement	<input type="checkbox"/> Other (please explain)	

Health and Prescription Plan	Retiree Only	Retiree + One	Family	Cancel Coverage
Only fill out this section to enroll in, change or cancel health coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSU Medicare Advantage Plan - Everyone in this plan must have Medicare Part B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSU Non-Medicare Plan - Nobody in this plan is enrolled in Medicare Part B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSU Transition Plan ² - One or more people are enrolled in Medicare Part B, but not all	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental Plan (please choose only one plan for all members)	Retiree Only	Retiree + One	Family	Cancel Coverage
<input type="checkbox"/> Aetna Dental Premium Plan DMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Delta Dental Base Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Delta Dental Premium Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ A Social Security Number (SSN) & 11-digit Medicare Beneficiary Identifier (MBI) are required for individuals enrolling in the MSU Medicare Advantage Plan.

² Individuals who are on Medicare will be enrolled in the MSU Medicare Advantage Plan. Individuals not enrolled in Medicare will be enrolled in the MSU Non-Medicare Plan.



Enrolling and Updating Eligible Dependents – dental plan must match the retiree's plan

To add/delete a dependent to/from your health/prescription and dental plans, please fill out the dependent information below. When adding a new dependent due to marriage, birth, or adoption, provide supporting documentation by attaching to this form. Information about eligible dependents and required documentation is located at www.hr.msu.edu/benefits/documents/EligibleDependents.pdf.

If you are adding an other eligible individual (OEI), you will also need to complete an [Other Eligible Individual Registration Form](http://www.hr.msu.edu/benefits/other-eligible-individual/index.html). Information outlining the enrollment guidelines for OEI's is available online at www.hr.msu.edu/benefits/other-eligible-individual/index.html.

If your dependent(s) is enrolled in another Medicare Advantage plan, they will be automatically disenrolled from that plan if you enroll them in the MSU Medicare Advantage Plan (MAPD).

Enrolling Eligible Dependents

Dependent Name (Last, First, Middle)	Social Security Number	Date of Birth (MM/DD/YY)	Gender (M/F)	Relationship	Enroll in MSU Health, Dental or Both	Enrolled in Medicare Part B?	Medicare Beneficiary Identifier ¹

Removing Dependent Coverage

Dependent Name (Last, First, Middle Initial)	Social Security Number	Disenroll in MSU Health, Dental or Both	For COBRA notification, please provide the dependent's address if they are not living with the subscriber.

Optional Employee-Paid Life

To change your beneficiary for Employee-Paid Life Insurance, visit www.hr.msu.edu/benefits/beneficiaries.html for more information.

☐ Cancel Employee Life ☐ Cancel Child(ren) Life ☐ Cancel Spouse/Other Eligible Individual (OEI) Life ☐ Cancel All Life

Authorization – Please read, sign, and date this section.

I am applying for and/or changing coverage as specified in the Group Agreements between MSU and my selected benefit plan(s). I understand that only those dependents listed on this form, who meet the definition of "Dependent" or "Sponsored Dependent", will be covered by the benefits I have elected (refer to the plan brochure for the definition of "Dependent").

I authorize my selected health, prescription, and dental plans to obtain, from providers of services and hospitals, the medical records relating to me and my enrolled spouse/OEI and dependent(s), which are necessary to the administration of my contract.

I have read and agree to the terms and conditions above and outlined in the plan brochures. I verify all information above is true, correct, and complete.

In the event your health, prescription, and dental coverage is cancelled due to non-payment, your next opportunity to re-enroll in coverage is the next Open Enrollment period or within 30 days of experiencing a mid-year qualifying life event (QLE).

Signature

Date

Please return the completed form by:

Mail/Drop Box: 1407 S. Harrison Rd., Suite 110, East Lansing, MI 48823
Fax Number: 517-432-3862
E-mail OR File Depot: SolutionsCenter@hr.msu.edu OR [FileDepot \(msu.edu\)](http://FileDepot.msu.edu)

For Office Use Only:

Date Received & Reviewed –
Staff Name –
PERNR –