Benefit Enrollment/Change Form

Select all applicable:
☐ New Enrollment ☐ Term Employment
☐ Add Dependent ☐ Term Dependent

Macomb Community College
Education • Enrichment • Economic Development
Discover. Connect. *Advance.*℠

1. Subscriber Information

ID# _____ Social Security Number_____ Date of Birth _____ Bargaining Unit _____ Date of Hire/Rehire _____

Last Name _____ First Name _____ Initial _____ ☐ Female ☐ Male

Address _____ City _____ State _____ Zip _____ Coverage Effective Date _____

2. Subscriber Benefit Enrollment/Coverage Information

☐ Keep current plan (*Select current health plan below*) ☐ New Enrollment / Plan Change (*Select new health plan below*)

Health Plan Election: ☐ PPO - BCBS ☐ HDHP - BCBS (*If you are electing this plan you must also complete the HSA Enrollment Packet.*)
☐ I am declining health coverage at this time. (*You must complete a Waiver of Coverage form and provide proof of coverage.*)

Dental Coverage: ☐ New Enrollment ☐ Currently Enrolled ☐ Decline Coverage

Vision Coverage: ☐ New Enrollment ☐ Currently Enrolled ☐ Decline Coverage

Dependent information is required for new enrollment or changes.
C = Currently Enrolled Dependent
A = New Enrollment (Adding dependent(s) to new/existing coverage.)
T = Terminate Coverage
D = Decline Coverage

3. Dependent Benefit Enrollment

Are you under court order to provide health coverage? ☐ Yes ☐ No

Below, list all dependents(s) and the coverage/change for each dependent:

	Last Name	First Name	Middle Initial	Check: F=Female M=Male	Date of Birth	Social Security Number	Indicate: C / A / T / D (Reference table above)			ID Number (HR ONLY)
							Medical	Dental	Vision	
Spouse				☐ F ☐ M						
Child				☐ F ☐ M						
Child				☐ F ☐ M						
Child				☐ F ☐ M						

*Supporting documentation is required for new enrollment of dependent(s).

Benefit Enrollment/Change Form

Macomb Community College
Education • Enrichment • Economic Development
Discover. Connect. *Advance.*℠

Additional Dependents:

	Last Name	First Name	Middle Initial	Check: F=Female M=Male	Date of Birth	Social Security Number	Indicate: C / A / T / D (Reference table on page 1)			ID Number (HR ONLY)
							Medical	Dental	Vision	
Child				☐ F ☐ M						
Child				☐ F ☐ M						
Child				☐ F ☐ M						
Child				☐ F ☐ M						

*Supporting documentation is required for new enrollment of dependent(s).

4. Medicare Coverage

Are you or a dependent Medicare eligible? ☐ Yes ☐ No If yes, effective dates: Part A _____ Part B _____

Medicare Eligible Last Name _____ First Name _____ Initial _____

5. Coordination of Benefits

Are you or any of your dependents covered by any other medical coverage? ☐ Yes ☐ No

If yes, please check those who have such coverage: ☐ Self ☐ Spouse ☐ Child(ren)

Name of Carrier _____ Policy # _____ Type of Coverage _____

6. Subscriber Certification

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that the failure to disclose true and accurate information may result in the immediate termination of the benefits. I understand that the benefits will not be in effect until I have satisfied the eligibility requirements for coverage under the Plan. I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical related facility, insurance or reinsurance company or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named dependents, to give to the Plan, its legal representative, management care firm, pre-certification or utilization review firm, any and all such information.

Signature _____ Print Name _____ Date _____