WESTERN MICHIGAN UNIVERSITY
Human Resources
1300 Seibert Administration Building, Mail Stop 5217
Phone (269) 387-3620 Fax (269) 387-3441

PPO

PPO Health Insurance Enrollment and Change Form

Eligible employee groups: AFSCME, MSEA, POA, Non-Bargaining Exempt, Non-Bargaining Nonexempt

Employee/Subscriber Information

Social Security Number	BCBS Group and Division # **007005281 -**	Date of Hire	Employee Department	Employee Group	Employee ID
Effective Date	Last Name	First Name	MI	Date of Birth	Home Phone
Home Address	City	State	Zip Code	Gender ☐ M ☐ F	Marital Status ☐ S ☐ M	Work Phone

Plan: Community Blue PPO

- ☐ Waive upon hire
- ☐ Terminate coverage
- ☐ Single (employee only)
- ☐ Double (employee & 1 family member)
- ☐ Family (employee & 2 or more family members)

Desired Action – Enroll or Cancel

Reason for Enrollment

- ☐ New Hire/Rehire
- ☐ Surviving Spouse
- ☐ Marriage
- ☐ Birth/Adoption/Foster Care
- ☐ DEI Event
- ☐ Open Enrollment
- ☐ Return to Work (LOA)
- ☐ Other Reason:
- ☐ Cobra Enrollment
- ☐ Transfer

New Suffix:

Reason for Cancellation

- ☐ No Longer Employed
- ☐ Deceased
- ☐ Divorce Status
- ☐ LOA
- ☐ Other Reason:
- ☐ Open Enrollment
- ☐ Other Insurance
- ☐ Loss of Dep Status

List all dependents to be enrolled/cancelled		Last Name	First Name	MI	Gender	Date of Birth	Social Security
☐ Spouse ☐ DEI Adult	☐ Add ☐ Remove				☐ M ☐ F		
☐ Child Age 19 – 26 ☐ DEI Child ☐ Y ☐ N	☐ Add ☐ Remove				☐ M ☐ F		
☐ Child Age 19 – 26 ☐ DEI Child ☐ Y ☐ N	☐ Add ☐ Remove				☐ M ☐ F		
☐ Child Age 19 – 26 ☐ DEI Child ☐ Y ☐ N	☐ Add ☐ Remove				☐ M ☐ F		
☐ Child Age 19 – 26 ☐ DEI Child ☐ Y ☐ N	☐ Add ☐ Remove				☐ M ☐ F		

If the permanent address of the spouse or child is difference from the Employee, Please complete the information below:

Spouse/Child – Full Name	Street Address	City	State	Zip
Child – Full Name	Street Address	City	State	Zip

Do you, your spouse or children maintain other health coverage? ☐ Yes ☐ No If yes, complete below

Full Name of Insured	Coverage Type	Insurance Company	Medicare Coverage: Part A Effective	Part B Effective	Claim Number
	☐ M ☐ D ☐ V				
	☐ M ☐ D ☐ V				

I have read and understand the conditions, eligibility, & required documentation on Page 2.

Employee Signature	Date	**HR USE ONLY**	HRA	Deduction Begin Date	Logged/Faxed to BCBSM

Please Read – Conditions for Enrollment/Cancellation

- I hereby authorize my employer or successor to make deductions from my earnings of the required contributions or premiums for the group coverage provided in the policy or policies issued to my employer. Additionally, I understand the contribution for the medical plan is made on a pre-tax basis.
- Note: If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance coverage, you will not be able to enroll again until the next open enrollment period. The only exception by law is a qualified family status change or life event. The enrollment must take place within 31 days of the family change or life event.
- I understand that if my employment is terminated, by voluntary resignation, involuntary resignation, or by any other fashion or method, upon re-employment, coverage will not become effective until I again apply for it in accordance with the terms of the group policy.

To the best of my knowledge and belief, the information I have provided is complete and correct.

Eligibility Definitions

Spouse

1. The legal spouse of a Subscriber.

Dependent Child

1. Child of a Subscriber by birth; by legal adoption; by legal foster care; or by legal guardianship where the Subscriber is legally obligated by court order to provide health insurance.
2. Child of a Subscriber's spouse by birth; by legal adoption; by legal foster care; or by legal guardianship for whom the Subscriber is legally obligated by court order to provide health insurance.

NOTE: A child is considered legally adopted on the date of placement for adoption by an authorized placement agency. A child as defined above is eligible for coverage until the limiting age of 26 under all specified eligibility provisions, or if the child is incapable of self-sustaining employment by reason of a physical or mental disability that was incurred prior to the limiting age and the child is considered a dependent on the Subscriber's federal income tax return.

Designated Eligible Individual (DEI)

An employee who does not already enroll a spouse in health insurance may enroll one adult individual for coverage provided the adult, at the time of proposed enrollment, **resides** in the same residence as the employee and has done so for at least the previous 18 consecutive months. The employee may also enroll a dependent child of an adult DEI provided the child resides with the employee. The employee may not designate his or her IRS dependents, relatives, or tenants. To enroll a DEI, an employee must complete and submit with this form the DEI enrollment form.

Family Status Change

A family status change or life event includes an employee's marriage or divorce, death of a spouse or child, birth or adoption of a child, meeting the DEI requirements, a change in the employee or spouse's employment or an unpaid leave of absence by the employee or spouse.

Required Documentation

The following documentation is required for enrollment of a dependent

1. Spouse – Copy of marriage certificate
2. Child – Copy of the birth certificate, proof of birth document from the hospital, or adoption or foster care placement paperwork
3. Stepchild – Copy of marriage certificate and the child's birth certificate
4. Disabled Child – Doctor's statement that certifies disability
5. Legal Obligation – Copy of the court order to provide health insurance to the specified dependent
6. Legal Guardianship – Copy of the court order entitling the Subscriber to full guardianship of the specified child

Designated Eligible Individual – DEI enrollment form and copies of the DEI's federal income tax returns to substantiate residency