



Wayne County  
 P/HR Benefit Administration Division  
 500 Griswold Street, 9th Floor  
 Detroit, MI 48226  
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# Enrollment / Change of Status Form

-- Please Print Using Dark Ink --

Section 1

## SUBSCRIBER (EMPLOYEE / RETIREE) INFORMATION: Complete Sections 1 - 5

Subscriber Contract No.	Emp ID No.	Subscriber Last Name	Subscriber First Name	M.I.
Home Address <input type="checkbox"/> <i>check if new</i>		City	State	Zip Code
Current Marital Status	Personal Phone	Work Phone	Employer Group	
Single <input type="checkbox"/> Married <input type="checkbox"/> ( )	( )	( )	Wayne Cnty <input type="checkbox"/>	3rd Cir Ct <input type="checkbox"/> WCAA <input type="checkbox"/>
Employee Status	Personal E-mail Address	Work E-mail Address		
Active Emp <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/>				

Section 2

### MEMBERS : List all persons to be enrolled / cancelled from your insurance contract on the appropriate line(s) below

MEMBER	ACTION (Circle One)	LAST NAME	FIRST NAME	MID. INIT	SEX	BIRTHDATE	SSN	RELATION. CODE*	PRIMARY CARE PHYSICIAN (HAP Mbrs Only)				
									LAST NAME	FIRST INIT	PHYS CODE	LOCATION	
SUBSCRIBER	ADD / CANCEL					/ /							
SPOUSE	ADD / CANCEL					/ /							
DEP-1	ADD / CANCEL					/ /							
DEP-2	ADD / CANCEL					/ /							
DEP-3	ADD / CANCEL					/ /							
DEP-4	ADD / CANCEL					/ /							
DEP-5	ADD / CANCEL					/ /							

\*RELATIONSHIP CODES: Please indicate all codes applicable for each person  
 N - Natural / Adopted Child    D - Disabled Child (PA 275)    S - Stepchild    C - Court Ordered Coverage    LF - Full Legal Guardianship    Enrollment of spouses and other dependents requires proof of relationship. Please see instructions on reverse for add'l info.  
 A - Child Adoption in Process    P - Principally Supported Child    SD - Sponsored Dep.    F - Child Age 19+ (Family Contin.)    LL - Limited Legal Guardianship

If the permanent address of the spouse and/or dependent is different from address in Section 1, please complete information below

Spouse (Full Name)	Street Address	City	State	Zip Code
Dependent (Full Name)	Street Address	City	State	Zip Code

Section 3

### OTHER COVERAGE: Do you or your spouse or dependent(s) maintain other health coverage? Yes No If yes, complete below

All Members Covered <input type="checkbox"/> (please check if yes)	Insurance Carrier	Group Policy Number	Carrier Location	Employer
Person Covered (Full Name)	Insurance Carrier	Group Policy Number	Carrier Location	Employer

Section 4

### CURRENT PLAN ELECTIONS: If you are currently enrolled as an employee or retiree in a County / Court sponsored health plan, check the applicable boxes for each line of coverage below

Medical Plan:  Blue Cross PPO     Health Alliance Plan (HAP)     Flexible Blue (High Ded. Plan)     Blue Cross Traditional Indemnity Plan     Opt Out Medical

Dental Plan:  Blue Cross Traditional Dental     Golden Dental Plan DMO     Dencap Dental DMO (ret. only)     Midwestern DMO (retirees only)     Delta Dental DMO (retirees only)     Waive Dental

Vision Plan:  Heritage Vision Plan     Optical Reimbursement Program     Waive Vision

### NEW PLAN ELECTIONS: If you are a new hire / new retiree electing or are making a plan change due to a special or open enrollment, check the applicable boxes for each line of coverage below

Medical Plan:  Blue Cross PPO     Health Alliance Plan (HAP)     Flexible Blue (High Ded. Plan)     Blue Cross Traditional Indemnity Plan     Opt Out Medical

Dental Plan:  Blue Cross Traditional Dental     Golden Dental Plan DMO     Dencap Dental DMO (ret. only)     Midwestern DMO (retirees only)     Delta Dental DMO (retirees only)     Waive Dental

Vision Plan:  Heritage Vision Plan     Optical Reimbursement Program     Waive Vision

Sect. 5

### I acknowledge that the information that I have completed on this form is true and accurate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Remarks: \_\_\_\_\_

Section 6

### --- FOR OFFICE USE ONLY ---

Enrollment Group No(s).	Effective Date of Enrollment	<input type="checkbox"/> New Hire / Rehire -- Date of Hire:	<input type="checkbox"/> Fall Open Enrollment	<input type="checkbox"/> Retiree Widow(er)	Medicare Eligibility Dates --	Contract Code:
		<input type="checkbox"/> New Retiree - Date of Retirement:	<input type="checkbox"/> Special Enrollment	<input type="checkbox"/> FT <input type="checkbox"/> PT	Part A:    Part B:	
Reason for Change / Group Nos.	Effective Date of Change	<input type="checkbox"/> Marriage <input type="checkbox"/> Dependent Change	<input type="checkbox"/> PT to FT	<input type="checkbox"/> Custodial Parent --	Name:	
		<input type="checkbox"/> Name Change -- From: _____ To: _____			FOC Case Number:	
COBRA Qualifying Event	Qualifying Date	<input type="checkbox"/> Divorce / Legal Separation	<input type="checkbox"/> Medicare Determination - Date:		Entered By:	
		<input type="checkbox"/> Loss of Dependent Status	<input type="checkbox"/> Not qualified for COBRA - notification provided beyond 60 days		Date:	

## INSTRUCTIONS FOR COMPLETING THE ENROLLMENT/CHANGE OF STATUS FORM

### SUBSCRIBER IS REQUIRED TO COMPLETE SECTIONS 1-5. ALL SECTIONS MUST BE COMPLETED BEFORE FORM CAN BE PROCESSED

**SECTION 1:** Enter subscriber information including: subscriber contract or social security number, last name, first name, middle initial, complete home address, marital status, personal phone number, work phone number, personal e-mail address and work e-mail address.

**SECTION 2:** List all persons that you wish to enroll or cancel in the appropriate row. ATTACH ADDITIONAL ENROLLMENT/CHANGE OF STATUS FORM(S) IF NECESSARY TO ADD / CANCEL MORE DEPENDENTS. Provide name, sex, birth date, social security number, and relationship code for each person listed. For HAP enrollment, use the provider directory booklet or access the Internet provider directory at [www.hap.org](http://www.hap.org) to obtain the provider name, physician code and location of the primary care physician (PCP) selected for each person listed. Complete the alternate address portion on this section if it applies to any listed dependent.

To enroll a spouse or dependent, proof of relationship must be attached to the form (i.e., marriage certificate, birth certificate(s), adoption and/or guardianship order(s), etc.). Spouses and children must be enrolled within thirty (30) days of date of hire, marriage, birth or during the annual health insurance open enrollment period. To enroll a sponsored dependent, you must attach a completed Sponsored Dependent Affidavit and an IRS form 4506-T so that Benefits Administration can request a copy of your most recent income tax return. **Note:** Sponsored dependents are eligible for basic medical and prescription drug coverage only. No dental or vision coverage applies). To cancel a spouse, a copy of the cover page, signature page, dependent information and COBRA or insurance information page from the divorce order is required for the purpose of determining eligibility for COBRA healthcare continuation. Other dependents may be cancelled at any time unless enrollment is required due to court order. Other documentation for enrollment and cancellation may be required based on the circumstances. If this is the case, you will be contacted with further instructions.

**SECTION 3:** If any person listed in Section 2 has other medical insurance coverage either through a group or on an individual basis, please check the "Yes" box. Indicate person covered, carrier, group/policy number, carrier location, and other employer name. Also, if you or any person listed in Section 2 has Medicare coverage, please check the "Yes" box. If yes, attach a copy of the Medicare card(s) and continue completion of this section. If Medicare coverage applies, enrollment will not be process without a copy of Medicare card.

**SECTION 4:** Check the appropriate box for medical and dental insurance that you are to be enrolled in or if you are currently enrolled in. If you elect to opt out of your County offered medical, you must provide proof of other insurance by attaching a letter from the other employer or insurance company stating you have coverage. You must also attach a completed Reduction in Health Care Benefit Health Care Insurance Opt Out Election Form.

Open Enrollment Elections Only – Check the appropriate box of the medical you wish to change to. If you elect to opt out of your County offered medical, you must provide proof of other insurance by attaching a letter from the other employer or insurance company verifying that you have coverage. You must also attach a completed Opt Out Election Form. There is no rebate for opting out of dental or vision benefits.

**SECTION 5:** You must sign the form and indicate date form is completed.

**SECTION 6:** To be completed by the Benefits Administration - Benefits Unit

**Enrollment Group No.:** Indicate the new group number, effective date, date of hire or retirement, subscriber's status, event, Medicare date(s) and contract number.

**Change Group Numbers:** Indicate the reason and date for change. If sponsored dependent or family continuation change, include charge.

**COBRA Qualifying Date:** Enter the COBRA qualifying and notification dates. Also, indicate reason for COBRA.

**Medicare Status:** Indicate Medicare determination date(s).

### PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT/CHANGE TO:

Wayne County

P/HR Benefits Administration

500 Griswold Street, Suite 900

Detroit, Michigan 48226

Office: (877) 220-7721 or (313) 224-7721 Fax: (313) 967-1228

E-mail: [benefits@co.wayne.mi.us](mailto:benefits@co.wayne.mi.us)



