OG

University of Michigan

Retiree Benefits Re-enrollment Form

Print information in **black** ink. Completed and signed form must be postmarked by the last day of Open Enrollment.

1. Retiree Information

Name (Last, First, Middle Initial)	Daytime Phone Number	UMID	U.S. Social Security Number (If UMID is unknown)

2. Benefit Plan Selections "Adult" refers to your spouse or other qualified adult

A. Health Plan Options

☐ Michigan Care Advantage* U-M Premier Care Advantage* Medicare Advantage PPO

☐ You only ☐ You + Adult ☐ You + Adult + Child(ren) ☐ Adult + Child ☐ Adult + Children

*You must live in the service area to be eligible. Visit hr.umich.edu/health-plans to check your eligibility.

B. Dental Plan Options

☐ Option 1 ☐ Option 2 ☐ Option 3

☐ You only ☐ You + Adult ☐ You + Adult +Child(ren) ☐ Adult + Child ☐ Adult + Children

C. Vision Plan

☐ Enroll ☐ Waive Coverage

☐ You only ☐ You + Adult ☐ You + Adult +Child(ren) ☐ Adult + Child ☐ Adult + Children

D. Legal Services Plan

☐ Enroll ☐ Waive Coverage

☐ You only ☐ You + Adult ☐ You + Adult +Child(ren) ☐ Adult + Child ☐ Adult + Children

3. Confirmation of Continuous Coverage

Provide the medical and prescription drug coverage below for you and/or your dependents that demonstrates that you had continuous coverage since the time you waived your U-M coverage. You will only be permitted to add dependents who were eligible for coverage under your U-M plans as of your retirement date. You will not be permitted to enroll any dependent not identified below.

Name (Last, First, Middle Initial)	Rel. Code*	Insurance Company Name	Policy Number	Policy Type (Group or Individual)	Coverge Effective Date

*Relationship Codes: SL = Self; SP = Spouse; C = Child; SA = Other Qualified Adult (OQA); CO = Child of OQA; SC = Stepchild; GC = Grandchild; R = Other Relative (niece or nephew); SB = Sibling

4. Medicare If any of the dependents listed above are eligible for Medicare, provide the exact information from the Medicare card.

First Name	Medicare Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date	Part D (Rx) Effective Date

5. Certification and Signature

I have read and agree to the terms and conditions listed above. The information I have provided is correct and to the best of my knowledge.

Retiree Signature ____________________ Date Signed ____________________

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?
Visit hr.umich.edu/benefits-wellness, or call the Shared Services Center - HR Customer Care at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.) Monday through Friday from 8 a.m. to 5 p.m. EST.

Receipt Confirmation

A confirmation email will be sent to your UMICH email address once the form is processed.

How to Return Your Signed and Completed Form

By FAX

Fax it to 734-763-0363. Keep a copy of the fax transmission report with your form in your records.

By Mail

Make a copy for your records and send the original by **Campus Mail or U.S. Mail to:**
SSC Benefits Transactions
3003 South State Street
Ann Arbor, MI 48109-1276

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