

University of Michigan

# Living Outside the Managed Care Service Area

Please print all information in **black** ink.

**For BTT Use Only**

Event Date \_\_\_\_\_

Input Elections \_\_\_\_\_

**NOTE:** This form must be received by SSC Benefits Transactions **within 14 days** of the date you receive an email with the subject line, "Living Outside the Premier Care Service Area." Coverage for you and your dependent(s), if any, has been defaulted into the Comprehensive Major Medical health plan. Complete and return this form to select a different plan. Your coverage will be effective the date you are newly eligible to enroll in a University of Michigan health plan.

### U-M Faculty, Staff Member, or Retiree Information

Name (Last, First, Middle Initial)	Daytime Phone	UMID (Social Security Number if unknown)
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### Select a Health Plan

Please change my U-M health plan from Comprehensive Major Medical to:

BCBSM Community Blue PPO	Medicare Advantage PPO
BCBSM Consumer-Directed Health Plan with Health Savings Account (HSA annual election amount: \$ _____ )	U-M Premier Care Advantage (If you are living in the Premier Care service area and you have updated your home address with U-M)
Premier Care (If you are living in the Premier Care service area and you have updated your home address with U-M)	

Visit [hr.umich.edu/health-plans](http://hr.umich.edu/health-plans) to learn more about your U-M health plan options verify your eligibility.

### Certification and Signature

I understand that I cannot make further changes to my health plan enrollment until the next Open Enrollment period (usually in October with changes effective January 1). I have read and agree to the terms and conditions on page 2 of this form.

\_\_\_\_\_  
Signature of Faculty, Staff Member, or Retiree

\_\_\_\_\_  
Date Signed

# Living Outside the Managed Care Service Area

## Terms and Conditions

By signing this form you agree to abide by the following:

### IRS Section 125 Restrictions

Dependents can only be added or deleted mid-year if a qualified family status change occurs which is consistent with the benefits change that is being made. Notify the SSC - HR Customer Care of the family status change by completing the required forms within 30 days of the event. If you fail to notify the SSC - HR Customer Care within 30 days of the event, you must wait until the next Open Enrollment in which you are eligible to participate to make the change. Qualified family status changes are defined by the Internal Revenue Service and include marriage, divorce, the birth or adoption of a child, death of a dependent, or a change in employment status (for you, your spouse or eligible dependent), such as a leave of absence without salary, a job termination or new job commencement.

### How to Make the Change

You need to complete and submit this form **within 14 days** of the date you received the email with the subject line, "Living Outside Premier Care Service Area." Your new coverage will become effective the first day of the month following the move or the receipt of this form, whichever is later.

## Release of Information

The Benefits Office will not release any information about you except:

- (1) when you request it in writing, or
- (2) when the release is necessary to process or review a claim (for example, to another insurance company).

If requested to do so, the Benefits Office will notify you of the information released and to whom.

## Important Notice

You cannot cover under your University of Michigan benefits plans:

- (1) Anyone who works for the university and has his or her own coverage as an employee of the university.
- (2) Any eligible dependents who are already covered by another employee of the university, unless you are court-ordered to provide such coverage.
- (3) Anyone who is not your legal spouse or eligible dependent.
- (4) Yourself if you are covered by another University of Michigan employee in the same plan.

When you sign this change form, you confirm that you understand and agree that claiming such coverage is misconduct, and you agree to reimburse the university for any additional costs incurred as a result of that misconduct.

## Authorization

You authorize any doctor, hospital or other provider rendering service to you or your dependents to furnish to the plan you have selected on this application any information requested concerning medical information, claims and other insurance payments. If you enroll in the CDHP, you understand that your enrollment and health information will be shared with HealthEquity for the purpose of administering and coordinating payments under your health savings account.

## Requested Documentation

The university reserves the right to require proof of dependency upon request. When you sign this form, you agree to provide such documentation upon request.



HUMAN RESOURCES  
**BENEFITS OFFICE**  
UNIVERSITY OF MICHIGAN

### Questions?

If you have any questions, view [hr.umich.edu/benefits-wellness](http://hr.umich.edu/benefits-wellness), or call SSC - 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 1 p.m. and 2 to 5 p.m. Eastern Time.

## 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  
Wolverine Tower  
3003 South State Street  
Ann Arbor, MI 48109-1276