HC

University of Michigan

Moving Out of a 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 30 days** of the date of the move. Your new coverage will become effective the first day of the month following the move or the receipt of this form, whichever is later (for COBRA coverage information, refer to page 2).

U-M Faculty, Staff Member, or Retiree Information

Name (Last, First, Middle Initial)	Daytime Phone	UMID (Social Security Number if uknown)

I have relocated/will relocate to: _____
Address

_____, _____ _____ on _____.
City State Zip Effective Date

Please change my current U-M health plan **FROM**: ☐ U-M Premier Care ☐ U-M Premier Care Advantage

TO:
- ☐ BCBSM Community Blue PPO
- ☐ BCBSM Consumer-Directed Health Plan with Health Savings Account (HSA annual election amount: $ _____)
- ☐ Comprehensive Major Medical
- ☐ Medicare Advantage PPO

Certification and Signature
I understand I cannot re-enroll in my current U-M health plan until the next Open Enrollment period. 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

Only My Dependent(s) is/are Relocating

My dependent (s), _____ , has relocated/will relocate out of my managed care service area
Name of Dependent(s) (Attach an additional sheet if necessary)
on _____. This move is temporary: ☐ Yes ☐ No Reason for move _____
Effective Date

Please select one: ☐ Delete my dependent(s) from my U-M health plan coverage (including prescription drug coverage)**

-OR- Change my coverage **FROM**: ☐ U-M Premier Care ☐ U-M Premier Care Advantage

TO:
- ☐ BCBSM Community Blue PPO
- ☐ BCBSM Consumer-Directed Health Plan with Health Savings Account (HSA annual election amount: $ _____)
- ☐ Comprehensive Major Medical
- ☐ Medicare Advantage PPO

Certification and Signature
** **Faculty and Staff**: I understand that I cannot re-enroll this/these dependent(s) in my U-M health plan until the next Open Enrollment period.
Retirees: I understand that I cannot re-enroll this/these dependent(s) in my U-M health plan once they have been removed from my coverage.

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

Moving Out of a 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 Enroll-ment 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.

Moving Outside of a Managed Care Service Area Normally, you cannot change your U-M health plan coverage during the plan year (January 1 through December 31). However, if you are covered by an HMO or managed care plan and move outside the plan's service area, you must change your health plan during the year.

How to Make the Change
You need to complete and submit this form **within 30 days of the date of the move**. Your new coverage will become effective the first day of the month following the move or the receipt of this form, whichever is later.

COBRA
Your submitted election will be effective when your COBRA coverage becomes active, if this form is received with your COBRA election paperwork. Otherwise, it will be effective the 1st day of the month following receipt of the form.

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, 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
1000 Victors Way
Ann Arbor, MI 48108