Enrollment Request
Due to Loss of Previous Coverage

☐ Health Plan ☐ Dental Plan

Employee/Retiree Name: _____ _____
Last,First MI Last 4 of SSN or ZPID

Previous Coverage Information

Insured's Name: _____

Employer's Name: _____

Name of Former Group Health and/or Denal Carrier: _____

Identification Numbers:_____ Termination Date:_____

Group #:_____ Contact #:_____
Reason for Coverage termination:

Group #:_____ Contact #:_____
Reason for Coverage Termination:

1. Applicant must apply for transfer into an MSU group health and/or dental plan within 30 days of a voluntary or involuntary termination (such as death, divorce, terminated employment, etc.) from the former group health and/or dental plan.
2. The former group health and/or dental plan must be independent of any program now existing in this group.
3. All applicants must be eligible for coverage as an employee of this group.
4. The applicant is entitled to all benefits under the group plan.
5. Coverage will become effective as of the date following termination of the previous group health and/or dental plan. Due to the Centers for Medicare and Medicaid rules, Retirees and/or dependents enrolling due to loss of previous coverage in Humana Medicare coverage will have enrollment first of the following month.

Please attach a copy of the previous health and/or dental plan identification card.

I have read and understood the above information. I hereby certify that the information supplied by me is true and request coverage for my family and myself in the health and/or dental plan sponsored by my employer.

_____ _____
Employee Signature **Date**

You can return this form by:

Mail address/Drop Box:	1407 S Harrison Rd., Suite 110, East Lansing MI 48823-5287
Fax Number:	517-432-3862
E-mail:	SolutionsCenter@hr.msu.edu (send securely)
File Depot:	FileDepot (msu.edu)