Human Resources
MICHIGAN STATE UNIVERSITY

2025 Retiree Offline Enrollment/Change Form

Do **NOT** complete this form if you completed enrollment online at ebs.msu.edu.

Please complete and return this form to enroll, change, or cancel benefits for you and/or your eligible dependent(s). If you have a qualifying life event (QLE), forms must be received by MSU Human Resources no later than **30 days** after the event. For more information regarding enrollment and qualifying life events, please contact MSU Human Resources at SolutionsCenter@hr.msu.edu or 517-353-4434 (toll-free; 800-353-4434).

Personal Information – Please Print Clearly

Retiree Name (Last, First, Middle Initial)	Social Security Number[1] or ZPID	Phone	
Home Street Address	Home City	Home State	Home Zip Code
If your spouse/other eligible individual (OEI) is an MSU employee/retiree, indicate their full name:			
Are you enrolled in any other health plan? ☐ Yes ☐ No If you are enrolled in another Medicare plan, you will be automatically **disenrolled** from that other plan if you enroll in the **MSU Medicare Advantage Plan**.	Retiree Medicare Beneficiary Identifier (MBI)[1] On your Medicare card, MBI is the 11-digit identifier under the title "Medicare Number"		

Reason for Completing This Form

☐ **Benefit Exception**	☐ **Birth/Adoption**	☐ **Dependent Arrival in the US**	☐ **Divorce**	☐ **Loss of Previous Coverage (LOPC)**
☐ **Marriage**	☐ **Newly Eligible**	☐ **Obtaining Other Coverage**	☐ **Retirement**	☐ **Medicare Eligibility**
☐ **Other**				**Event Date:**

Health Plan

Health Plan	Retiree	Retiree + One	Family	Cancel Coverage
Only fill out this section to enroll in, change or cancel health coverage				
MSU Medicare Advantage Plan - Everyone in this plan must have Medicare Part B	☐	☐	☐	☐
MSU Non-Medicare Plan - Nobody in this plan is enrolled in Medicare Part B	☐	☐	☐	☐
MSU Transition Plan[2] - One or more people are enrolled in Medicare Part B, but not all	N/A	☐	☐	☐

Enroll Eligible Dependent(s) in Health

To **add** an eligible spouse/other eligible individual (OEI) or dependent(s) to your health plan, please provide all the requested information for each dependent in the spaces below.

Dependent Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (MM/DD/YY)	Sex (M/F)	Relationship	Enrolled in Medicare Part B? Yes	Enrolled in Medicare Part B? No	Medicare Beneficiary Identifier (MBI)[1]
					☐	☐	
					☐	☐	
					☐	☐	

If your dependent(s) is enrolled in another Medicare Advantage plan, they will be **automatically disenrolled** from that other plan if you enroll them in the MSU Medicare Advantage Plan.

Dental Plan

Dental Plan	Retiree	Retiree + One	Family	Cancel Coverage
Only fill out this section to enroll in, change or cancel dental coverage				
Aetna Premium DMO	☐	☐	☐	☐
Delta Dental Base Plan	☐	☐	☐	☐
Delta Dental Premium Plan	☐	☐	☐	☐

[1] An SSN and MBI are required for individuals enrolling in the MSU Medicare Advantage Plan. If an SSN is on this form, please do not submit via email.
[2] Individuals who are on Medicare will be enrolled in the MSU Medicare Advantage Plan. Individuals not enrolled in Medicare will be enrolled in the MSU Non-Medicare Plan.

For Office Use Only:
Date Received _____ HR Staff Member _____
Date Reviewed _____ HR Staff Member _____

Please turn over →

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Enroll Eligible Dependent(s) in Dental

To **add** an eligible spouse/other eligible individual (OEI) or dependent(s) to your dental plan, please provide all the requested information for each dependent in the spaces below.

Dependent Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (MM/DD/YY)	Sex (M/F)	Relationship

Remove Dependent(s) from Health and/or Dental Plans

To **remove** an existing dependent(s) from your plan, list the person(s) below.

Dependent Name (Last, First, Middle Initial)	Social Security Number	Delete MSU Coverage?	
		Health	Dental
		☐	☐
		☐	☐

Employee-Paid Life[3]

- ☐ Cancel Employee Coverage Only
- ☐ Cancel Spouse/Other Eligible Individual (OEI) Coverage Only
- ☐ Cancel Child(ren) Coverage Only

Authorization – Please read, sign, and date this section.

I am applying for and/or changing coverage as specified in the Group Agreements between MSU and my selected benefit plan(s). I understand that only those dependents listed on this form who meet the definition of "Dependent" will be covered by the benefits I have elected (refer to the plan brochure for the definition of "Dependent").

I authorize my selected health plan to obtain, from providers of services and hospitals, medical records relating to me and my enrolled spouse/other eligible individual (OEI) and/or dependent(s), which are necessary to the administration of my contract.

I have read and agree to the terms and conditions above and outlined in the plan brochures. I verify all above information is true, correct, and complete.

In the event your health, prescription, and dental coverage is cancelled due to non-payment, your next opportunity to re-enroll in coverage is the next Open Enrollment period or within 30 days of experiencing a mid-year qualifying life event (QLE).

You can return this form by:

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

Signature _____ Date _____

[3] If you want to change your beneficiary for Employee-Paid Life Insurance, visit www.hr.msu.edu/benefits/beneficiaries.html for more information.