

**INSTRUCTIONS FOR COMPLETING THE ENROLLMENT/CHANGE OF STATUS FORM
ALL SECTIONS MUST BE COMPLETED BEFORE FORM CAN BE PROCESSED**

SUBSCRIBER IS REQUIRED TO COMPLETE SECTIONS 1-5:

SECTION 1: Enter subscriber information including: subscriber contract or social security number, last name, first name, middle initial, complete home address, marital status, personal phone number, work phone number, personal e-mail address and work e-mail address.

SECTION 2: List all persons that you wish to enroll or cancel in the appropriate row. ATTACH ADDITIONAL ENROLLMENT/CHANGE OF STATUS FORM(S) IF NECESSARY TO ADD / CANCEL MORE DEPENDENTS. Provide name, sex, birth date, social security number, and relationship code for each person listed. **For HAP enrollment**, use the provider directory booklet or access the Internet provider directory at www.hap.org to obtain the provider name, physician code and location of the primary care physician (PCP) selected for each person listed. Complete the alternate address portion on this section if it applies to any listed dependent.

To enroll a spouse or dependent, proof of relationship must be attached to the form (i.e., marriage certificate, birth certificate(s), adoption and/or guardianship order(s), etc.). Spouses and children must be enrolled within thirty (30) days of date of hire, marriage, birth or during the annual health insurance open enrollment period. **To cancel** a spouse, a copy of the cover page, signature page, dependent information and COBRA or insurance information page from the divorce order is required for the purpose of determining eligibility for COBRA healthcare continuation. Other dependents may be cancelled at any time unless enrollment is required due to court order. Other documentation for enrollment and cancellation may be required based on the circumstances. If this is the case, you will be contacted with further instructions.

SECTION 3: If any person listed in Section 2 has other medical insurance coverage either through a group or on an individual basis, please check the “Yes” box. Indicate person covered, carrier, group/policy number, carrier location, and other employer name. Also, if you or any person listed in Section 2 has Medicare coverage, please check the “Yes” box. If yes, attach a copy of the Medicare card(s) and continue completion of this section. If Medicare coverage applies, enrollment will not be process without a copy of Medicare card.

SECTION 4: Check the appropriate box for medical and dental insurance that you are to be enrolled in or if you are currently enrolled in. If you elect to opt out of your County offered medical, you must provide proof of other insurance by attaching a letter from the other employer or insurance company stating you have coverage. You must also attach a completed Reduction in Health Care Benefit Health Care Insurance Opt Out Election Form.

Open Enrollment Elections Only – Check the appropriate box of the medical you wish to change to. If you elect to opt out of your County offered medical and/or dental, you must provide proof of other insurance by attaching a letter from the other employer or insurance company stating you have coverage. You must also attach a completed Opt Out Election Form. There is no rebate for opting out of dental or vision benefits.

SECTION 5: You must sign the form and indicate date form is completed.

GROUP IS REQUIRED TO COMPLETE SECTION 6 (This form cannot be processed for enrollment purposes without completion of the following):

Enrollment: Indicate the new group number, effective date, date of hire or retirement, subscriber’s status, event, Medicare date(s) and contract number.

Coverage Change Group Numbers: Indicate the reason and date for change. If sponsored dependent or family continuation change, include charge.

**COBRA
Qualifying**

Date: Enter the COBRA qualifying and notification dates. Also, indicate reason for COBRA.

**Medicare
Status:**

Indicate Medicare determination date.

PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT/CHANGE TO:

For Active, Retired, Custodial Parent and COBRA enrollees:

**Wayne County
P/HR Benefit Administration
600 Randolph Street, Room 171
Detroit, Michigan 48226
Office: (313) 224-7721 Fax: (313) 967-6027
E-mail: benefits@co.wayne.mi.us**