

University of Michigan

**2007 Benefits Enrollment Form**

For University of Michigan Benefit-Eligible Fellowship or Medical School Students

**1. How to Use This Form.**

You can use this form to enroll in your benefits for 2007. Please note that this form does not contain your personal benefits information nor does it contain any rates. Review the Benefits Office Web site at [www.umich.edu/~benefits](http://www.umich.edu/~benefits) to obtain information to assist you in making your benefits elections for 2007. When you complete, sign and return this form, you acknowledge that you understand and agree to abide by the eligibility, enrollment and election procedures for your University of Michigan benefits.

**2. Deadline and Defaults.**

You have 30 days from your first day of eligibility for benefits at the University to complete and return the benefits enrollment materials. Be sure to fully complete your choices and record your selections carefully. Failure to make a benefit election will be considered your election to waive that benefit or keep your default benefit election as follows:

- New Benefit-Eligible Fellowship students default to no coverage.
- Medical School students default to GradCare, You Only, coverage.
- Defaults occur after 30 days from when first eligible.

If you complete and submit this form, it will be recorded as your election until the next Open Enrollment. Once this form is submitted, you will not be able to make changes to your initial enrollment, even within the 30-day enrollment period, unless you have a qualified family status change.

**3. Effective Date.**

If you return your enrollment materials within the 30 days allowed, most benefits you choose will become effective as of your first date of eligibility with the University.

**4. Enrollment.**

- Use **black ink** to mark your choices.
- Complete all sections for each plan.
- Circle "No" in the Medical/Rx column in Section 2 on page 2 and check "Waive medical insurance" if you do not wish to enroll during 2007. Per U-M policy, Medical School Students must also complete item 1 on page 3 if waiving medical coverage.

- Failure to make a specific benefit election on this form will be considered your election to waive your benefit election or keep your default benefit election, if any.
- Sign and date where indicated.
- Return the signed and completed form to the HRRIS Benefits Transaction Team.

**5. Your Primary Care Physician**

All new members must choose a primary care physician (PCP) when joining a managed care medical plan. Your PCP must provide or arrange services in order for services to be covered. Contact M-CARE Customer Service by calling (734) 913-2211 to choose your PCP. M-CARE will select your PCP for you if you do not choose one. Selecting a PCP as soon as possible will ensure covered services are available to you.

**6. Medical Insurance ID Cards.**

Your GradCare medical insurance ID cards will arrive within six weeks from the date your enrollment form is processed. If you don't receive them, contact M-CARE Customer Service by calling (734) 913-2211.

**7. Frequency and Timing of Premium Payments.**

Premium payments, if any, will be charged to your student account on a monthly basis.

**8. Same-Sex Domestic Partners (SSDPs).**

Medical benefits provided to your same-sex domestic partner (SSDP) and his or her children will, under federal tax law, generally require taxation of the University contribution attributable to the partner and their children. However, if you declare your partner and the partner's children as legal dependents on your most recent federal income tax return, you can waive the taxation requirements. For more information, contact the HR/Payroll Service Center.

**Important Note: Do not submit this form if you have already enrolled online through eBenefits. Your eBenefits elections will be used for your 2007 enrollments if you make changes online and also submit a form.**

**M** Human Resources  
& Affirmative Action

Benefits Office

**Questions?**

If you have any questions, view the Benefits Office Web site at [www.umich.edu/~benefits](http://www.umich.edu/~benefits), or call the HRRIS Benefits Transaction Team at (734) 936-0258.

**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:

HRRIS Benefits Transaction Team  
4005 Wolverine Tower  
3003 South State Street  
Ann Arbor, MI 48109-1281

**Drop It Off In Person**

Bring a photocopy of your completed form and ask the receptionist to stamp the copy "received" for your records.

U-M Ann Arbor  
HR Service Center  
Wolverine Tower – Low Rise G250  
3003 South State Street  
Ann Arbor, MI 48109-1278

University of Michigan  
**2007 Benefits Enrollment Form**

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<p><b>For HRRIS BTT Use Only</b></p> <p>Event Date _____</p> <p>Input Elections _____</p>
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Print all information in **black** ink. All forms must be **received** by the HRRIS Benefits Transaction Team **within 30 days** after your first day of eligibility at the University. These elections remain in effect through December 31, 2007 unless you experience a qualified family status change.

**1. Fellowship or Medical School Student Information.**

Name (Last, First, Middle Initial)		UMID	U.S. Social Security Number (If UMID is unknown)
Street Address	City, State, Zip		Home Phone Number
Eligibility Date	Title	U-M Email Address	Daytime Phone Number

**2. Persons To Be Enrolled/Dependent Information.**

Complete **all** fields. Circle "Yes" to enroll in a benefit or "No" to **not** enroll.

Last Name	First Name	U.S. Social Security Number	Relationship Code <sup>1</sup>	Gender (M/F)	Date of Birth (MM/DD/YY)	Medical/Rx Plan
			<b>SL</b>			Yes No
						Yes No
						Yes No
						Yes No
						Yes No
						Yes No

**Total Enrolled**

<sup>1</sup>SL = Self; SP = Spouse; D = Daughter; S = Son; SP = Same-Sex Domestic Partner (SSDP)\*; SG = Daughter of SSDP\*; SN = Son of SSDP\*; SS = Stepson; SD = Stepdaughter; GC = Grandchild; NE = Nephew; NI = Niece; SI - Sister; B = Brother

\*Group insurance for these relationships generally requires taxation of the University's contribution. Coverage for these relationships is only allowed when certain criteria are met, including being claimed on your income tax return. Proof of eligibility may be required. See the Benefits Office Web site at [www.umich.edu/~benefits/eligibility](http://www.umich.edu/~benefits/eligibility) for details.

**3. Medical Insurance Options.** Enrollment in prescription drug coverage is automatic when you enroll in a U-M medical plan.

<b>Select one:</b>	
<b>GradCare</b>	<input type="checkbox"/> You Only <input type="checkbox"/> You + Adult* <input type="checkbox"/> You + Adult* + Child(ren) <input type="checkbox"/> You + Child <input type="checkbox"/> You + Children
<b>Waive medical insurance.</b>	<input type="checkbox"/> Check here to waive. Medical School Students must also complete item 1 on page 3. This also waives prescription drug coverage.

\* "Adult" refers to your spouse or same-sex domestic partner.

**4. General Provisions, Authorization and Confirmation of Benefits.** Signature required below.

**1. HIPAA.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your rights to Special Enrollment under any of the medical insurance plans offered by U-M when you or your eligible dependents (spouse/children) decline coverage during the initial enrollment period. If you are declining enrollment for yourself, or your dependents (spouse/children) because of coverage under another medical plan, you may in the future be able to enroll yourself or your dependents in a U-M medical plan, provided you request enrollment within thirty (30) days after your other coverage ends. In order to qualify for this special enrollment period, you must certify other coverage was the reason for declining enrollment and provide the source of that other coverage below.

**Medical School Student Other Coverage Certification**

I am waiving medical coverage because I have medical coverage elsewhere. I certify that I have other coverage either (1) through another U-M faculty, staff member or U-M benefit-eligible student (UMID) \_\_\_\_\_, (2) outside of the U-M through (Employee Name) \_\_\_\_\_ with (Employer Name) \_\_\_\_\_, or (3) through a governmental-sponsored health plan or private insurance policy (identify plan) \_\_\_\_\_. I understand that if I do not gain special enrollment rights upon a loss of other coverage, my next opportunity to enroll in a U-M medical insurance plan will be the next annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption. I understand that I am also waiving prescription drug coverage.

**2. Dependents.** Any dependents I am enrolling meet the eligibility requirements described in the benefit enrollment materials. Upon request, I will furnish a copy of my marriage license, same-sex domestic partner registration or termination, divorce decree, the section of my IRS Form 1040 listing dependents, court orders establishing guardianship or adoption, and/or the birth certificate of any individual for whom I seek benefits. By my signature on this enrollment form, I certify that I understand and agree that to claim coverage for an ineligible dependent is serious misconduct, and in the event of such conduct, I agree to reimburse U-M for any cost incurred, and may be subject to disciplinary action. If there is any change in the status of any of the individuals listed on this form, I will be responsible for notifying U-M within 30 days of such change.

**3. Release of Information.** By signing this form to enroll in benefits at U-M, I authorize any doctor, hospital or other provider who render service(s) to me or my eligible dependents to furnish to the medical insurance plan I select on this application any information that plan requests related to medical information, claims, and other insurance payments.

**4. Charged Premium Authorization.** I have reviewed the benefit enrollment materials and agree to the terms and conditions listed there. I authorize deductions, if appropriate, for my benefit choices based on the current rate and any future rate changes (increases or decreases).

**5. Affirmation and Understanding.** I affirm under penalty of perjury that the preceding statements are true and complete to the best of my knowledge. I further understand that any misrepresentation of these statements may result in serious consequences including loss of benefits, discipline or appropriate legal action.

**Confirmation and Acknowledgement**

You cannot cover under your U-M benefit plans: (1) Anyone who works for U-M and has his or her own coverage through U-M; (2) Any dependent child who works for U-M and is eligible for benefits as an employee of U-M; (3) Any eligible dependents who are already covered by another employee of U-M, unless you are court-ordered to provide such coverage; (4) Anyone who is not your legal spouse, same-sex domestic partner or eligible dependent; (5) Yourself if you are covered by another U-M employee as a dependent on their benefit plan. U-M employees cannot be covered as dependent children on another U-M employee's medical plan. When you sign this form, you confirm that you understand and agree that claiming such coverage is misconduct, and you agree to reimburse U-M for any additional costs incurred as a result of that misconduct.

\_\_\_\_\_  
**Signature of Benefit-Eligible Fellowship or Medical School Student**

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