

University of Michigan

# Moving Out of a Managed Care Service Area

Please print all information in **black** ink.

**NOTE:** This form must be received by the HRRIS Benefits Transaction Team **within 30 days** of the event.

**For HRRIS BTT Use Only**

Event Date \_\_\_\_\_  
Input Elections \_\_\_\_\_

### U-M Faculty, Staff Member, or Retiree Information

Name (Last, First, Middle Initial)	Daytime Phone	UMID	U.S. Social Security Number (If UMID is unknown)
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I have relocated/will relocate to: \_\_\_\_\_  
Address

\_\_\_\_\_ , \_\_\_\_\_  
City State Zip

on \_\_\_\_\_ .  
Effective Date

Please change my current medical insurance plan from:  Heal Alliance Plan  U-M Premier Care  Priority Health  COBRA GradCare  
to:  Blue Cross Blue Shield of Michigan Community Blue PPO  
 Comprehensive Major Medical

I understand I cannot re-enroll in my current U-M medical insurance plan until the next Open Enrollment period.

\_\_\_\_\_  
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 medical insurance coverage (including prescription drug coverage)\*\*  
-OR-  Change my coverage from:  Priority Health  Health Alliance Plan  U-M Premier Care  
to:  Blue Cross Blue Shield of Michigan Community Blue PPO  
 Comprehensive Major Medical

\*\* I understand that I cannot re-enroll this/these dependent(s) in my U-M medical insurance plan until the next Open Enrollment period.

\_\_\_\_\_  
Signature of Faculty, Staff Member, or Retiree Date Signed

# Moving Out of a Managed Care Service Area

## Terms and Conditions

By signing the front of 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 HR/Payroll Service Center of the family status change by completing the required forms within 30 days of the event. If you fail to notify the HR/Payroll Service Center within 30 days of the event, you must wait until the next Open Enrollment 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, registration or dissolution of a same-sex domestic partnership, 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 an HMO Service Area

Normally, you cannot change your medical insurance coverage during the plan year (January 1 through December 31). However, if you are covered by an HMO or point-of-service (POS) plan and move outside the plan's service area, you can change your medical insurance choice during the year.

### How to Make the Change

You need to complete and submit this form **within 30 days after the date you move**. Your new coverage will become effective the first day of the month after your move.

### 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 dependent child who works for the University and is eligible for benefits as an employee of the University.
- (3) Any eligible dependents who are already covered by another employee of the University, unless you are court-ordered to provide such coverage.
- (4) Anyone who is not your legal spouse or eligible dependent.
- (5) 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.

### 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.



### 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 HR/Payroll Service Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.).

## 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  
4073 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 your form "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

**U-M Flint  
UHR – Flint**  
213 University Pavilion  
303 East Kearsley Street  
Flint, MI 48502-1950