MEBS
Better Decisions. Better Healthcare.

Enrollment and Changes Form

Please mail or fax this completed and signed form to MEBS:
3809 Lake Eastbrook Blvd SE, Grand Rapids, MI 49546
Fax: (616) 458-3495. Questions? Please call (800) 968-6327.

Step 1. Employee Information

Today's Date	Last Name	First Name	Birth Date	Employer Name

Job Title	Annual Salary	Date of Full Time Status	Hours Work Per Week	SS # Medicare #

Home Address	Home Phone

☐ Single ☐ Married ☐ Male ☐ Female Enrollment ☐ New ☐ Revision ☐ Rehire ☐ Open Enrollment

Email (Optional): ____________________

Negotiated Coverage ☐ Basic Term Life $__________ ☐ Life $__________
☐ Dependent Life $__________ ☐ STD $__________ ☐ LTD $__________

Step 2. Dependents

		First Name	Last Name *(if different)*	Gender	Birth Date	SS or Medicare Number	Email (Optional)
Spouse	☐ Add ☐ Delete			☐ Male ☐ Female			
Dependent	☐ Add ☐ Delete			☐ Male ☐ Female			
Dependent	☐ Add ☐ Delete			☐ Male ☐ Female			
Dependent	☐ Add ☐ Delete			☐ Male ☐ Female			
Dependent	☐ Add ☐ Delete			☐ Male ☐ Female			
Dependent	☐ Add ☐ Delete			☐ Male ☐ Female			
Sponsored	☐ Add ☐ Delete			☐ Male ☐ Female			

Select Coverage	Medical	Dental	Vision	Rx	Wrap
Self	☐	☐	☐	☐	☐
2-Person	☐	☐	☐	☐	☐
Full Family	☐	☐	☐	☐	☐
Sponsored Dependent	☐	☐	☐	☐	☐
Complimentary	☐	☐	☐	☐	☐

Remarks:

Step 3. Coordination of Benefits for Existing Coverage *(Please complete if you, your spouse, or dependents maintain other health coverage)*

Employer	Employer Address		
Insurer/HMO	☐ Medical Group #	☐ Dental Group #	☐ Vision Group #

If Medicare applicable, **please provide a copy of the card.** Primary | Medicare ☐ BCBSM ☐ BCN | HIC #

Status: ☐ Over 65 and working ☐ Retired ☐ ESRD | Medicare ☐ Plan A ☐ Plan B ☐ Plan D | Effective Date

Step 4. Beneficiary Information

I make the nomination of beneficiary with respect to all insurance provided now or at any time in the future under Policy above mentioned, hereby revoking prior nominations for such insurance, if any, and reserve to myself the privilege of making other and further changes to the policy provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein. If no designated beneficiary survives me, settlement will be made as provided in the policy(ies). **If applicable, be sure to list a beneficiary for the $5,000 Life and AD&D insurance benefit included in the medical program or options.**

Check One ☐ Estate ☐ Individual	Last Name	First Name	Age
Relationship	Address		

Step 5. Employee Authorization

I have read and understand the conditions listed on the back of this form. Signature: Date:

Step 6. Employer Use: Reason for Enrollment Change

Effective Date for Change	Reason for Change	☐ Marriage ☐ Transfer to Retiree Suffix	☐ Adoption/Legal Guardian ☐ Loss of Coverage	☐ Name Change/Address ☐ Other *(Describe in Remarks section above)*	☐ COBRA

For loss of dependent status, list home address	Today's Date	Employer Signature

For MEBS Office Use Only

Coverage Elected Type					
	☐ Medical	☐ WRAP	☐ Rx	☐ Dental	☐ Neg. Life
	☐ Vision	☐ COBRA	☐ Stop Loss	☐ Other	☐ Neg. AD&D
	☐ Neg. STD	☐ Neg. LTD	Group No. Suffix		