

# Employee Benefit Change Form

<b>For MCC Use Only</b>	<input type="checkbox"/> Flex	<input type="checkbox"/> STD	<input type="checkbox"/> Life	BCBSM group/suffix ID	BCN group/subgroup/class ID
	<input type="checkbox"/> HI	<input type="checkbox"/> LTD	<input type="checkbox"/> LR		

**Reason for Submission** *To cancel Flexible Benefits, attach Flexible Benefit Change in Status Form. Lay Retirement must be cancelled through Gateway or Wage Report.*

<input type="checkbox"/> Change beneficiary designation for Life Insurance	<input type="checkbox"/> Request duplicate ID card	<input type="checkbox"/> Cancel Short Term Disability
<input type="checkbox"/> Change beneficiary designation for Lay Employees' Retirement Plan	<input type="checkbox"/> Change name/address/phone	<input type="checkbox"/> Cancel Long Term Disability
<input type="checkbox"/> Add dependents for medical and dental coverage	<input type="checkbox"/> Cancel Flexible Benefits	<input type="checkbox"/> Cancel Health Insurance
<input type="checkbox"/> Remove dependents for medical and dental coverage	<input type="checkbox"/> Cancel Life Insurance	

Details *For name change, provide name previously used. For any cancellation of benefits, provide effective date and reason for cancellation.*

**Employer Information** *To be completed by employer. Employer must sign and date this form for it to be valid.*

Unit name	Unit #	Health unit #
Signature		Date / /

**Employee Information** *Remaining sections to be completed by employee.*

SSN	Last name	First name	Middle name
Street address		City	State
Zip code	Phone number ( )	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married	

**Dependent Information for Medical and Dental Coverage** *Documentation required. List additional dependents on separate sheet of paper and attach.*

Addition due to:		Removal due to:	
<input type="checkbox"/> Birth	<input type="checkbox"/> Child by legal adoption	<input type="checkbox"/> Death of dependent	<input type="checkbox"/> Dependent losing status
<input type="checkbox"/> Child by legal guardianship (ward)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce from spouse	<input type="checkbox"/> Other
<input type="checkbox"/> Principal support	<input type="checkbox"/> Step child		
<input type="checkbox"/> Other			

  

SSN	Last name	First name	Date of birth / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Coverage selected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Effective date / /	

  

SSN	Last name	First name	Date of birth / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Coverage selected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Effective date / /	

  

SSN	Last name	First name	Date of birth / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Coverage selected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Effective date / /	

  

SSN	Last name	First name	Date of birth / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Coverage selected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Effective date / /	

**Employee Signature** *Unless terminated, you must sign and date this form for it to be valid.*

<input type="checkbox"/> I certify that the above information is correct to my knowledge/belief and I meet the terms stated under 'Terms, Conditions, and Additional Procedures'.	
Signature	Date / /

<b>Beneficiary Designation for Lay Employees' Retirement Plan</b> <i>List additional beneficiaries on separate sheet of paper and attach.</i>			
<input type="checkbox"/> I hereby revoke all prior beneficiaries. I understand that if I am married, the pre-retirement death benefit shall be paid to my surviving spouse, unless I have designated another beneficiary and my spouse has given written consent by submitting a Spousal Waiver Form (available from the MCC).			
<b>Primary</b>	SSN	Last name	First name
	Date of birth / /	Relationship	Percentage
<b>Contingent</b>	SSN	Last name	First name
	Date of birth / /	Relationship	Percentage
<b>Contingent</b>	SSN	Last name	First name
	Date of birth / /	Relationship	Percentage
<b>Beneficiary Designation for Life Insurance</b> <i>List additional beneficiaries on separate sheet of paper and attach.</i>			
<input type="checkbox"/> I hereby revoke all prior beneficiaries and designate the following primary beneficiaries to receive the proceeds of my life insurance, payable at my death. I understand that if this person is not living, the funds will go to the contingent beneficiaries. I also understand that if I name more than one primary or contingent beneficiary, the funds will be divided equally among those who are still living unless I have distinctly provided otherwise.			
<b>Primary</b>	SSN	Last name	First name
	Date of birth / /	Relationship	Percentage
<b>Contingent</b>	SSN	Last name	First name
	Date of birth / /	Relationship	Percentage
<b>Contingent</b>	SSN	Last name	First name
	Date of birth / /	Relationship	Percentage

### Terms, Conditions, and Additional Procedures

Employees are allowed to request changes in their membership and record status during the Open Enrollment Period or when a qualifying change in status occurs during the year in accordance with the relevant plan or policy (including, but not limited to marriage, divorce, birth or death).

The Michigan Catholic Conference (MCC) must receive notification of any change affecting a subscriber's contract within **thirty (30) days** of the event producing the change, unless otherwise required by law. The completed Employee Benefit Change Form must be submitted at the beginning of the month, or as close to the beginning of the month as possible.

Employees may add newly eligible members to their contracts, provided notice is given, on the Employee Benefit Change Form within **thirty (30) days** of the event. Beyond **thirty (30) days**, employees must wait until the open enrollment period to add members, unless otherwise required by law.

Employees should notify their employers of any changes in their address, as they occur, so membership information is kept current.

Members, including rider dependents, are removed from the contract when they become ineligible for coverage. It is the employee's responsibility to inform their employer, who will then notify the MCC.

Employees who marry and change their names should report their name change to their employer, who in turn should notify the MCC on the Employee Benefit Change Form completed by the employee.

Employees or their dependents that are no longer eligible for medical coverage under the MCC group health plan may convert their health plan to an individual conversion contract. They should contact the BCBSM regarding BCBSM PPO conversion information, BCBSM for supplemental coverage information, or the Blue Care Network HMO for HMO conversion information. There is no conversion for dental coverage. Please contact the MCC for telephone numbers.

Employees should keep their employer updated on coordination of benefits changes on themselves and/or family members as such changes occur by use of a Employee Benefit Change Form.

**The employee must always sign and date the Employee Benefit Change Form except when termination of employment occurs.**