Macomb County Human Resources Department

Open Enrollment Optional Change Form

ONLY COMPLETE IF YOU ARE MAKING A CHANGE

Section 1: General Information – Please Print Clearly

Name: Last, First, MI ______________________

Sex ☐ Male ☐ Female

Birth Date ________

Social Security Number (Last Four Digits) XXX- XX - ___ ___ ___ ___

Address: Street, City, State, Zip ______________________

Marital Status ☐ Single ☐ Married

Phone Number: ____________ **Retiree ID #:** ____________

Section 2: Insurance Information

CURRENT	*NEW SELECTIONS*
Vision	**Vision**
☐ BCBSM	☐ BCBSM
☐ No Coverage	☐ No Coverage
Dental	**Dental**
☐ Delta	☐ Delta
☐ No Coverage	☐ No Coverage
Hearing	**Hearing**
☐ Audionet	☐ Audionet
☐ No Coverage	☐ No Coverage

Section 3: Changes

Indicate which coverage(s) will be affected: ☐ Hearing ☐ Vision ☐ Dental

☐ Add Spouse ☐ Delete Spouse

	Last, First, MI	Sex	Birth Date	Social Security Number
Spouse	____________	☐ Male ☐ Female	________	________

Section 4: Acknowledgment

- I understand if I elect hearing a monthly deduction from the pension check will be required and will be adjusted annually. I fully understand that my election(s) can not be cancelled until open enrollment, or unless a qualifying event has occurred.
- I understand if I elect coverage for an eligible dependent, a monthly deduction from the pension check will be required and will be adjusted annually.
- I also understand if I have declined hearing coverage now, I will not be allowed to enroll until the next open enrollment period, or unless a qualifying event has occurred.
- I also understand that the changes made in Section 3 are true and accurate to the best of my knowledge.
- I also understand that I must apply for Medicare Part A and Part B when I become eligible.
- I understand that I must notify Human Resources within 30 days of any possible change in status of eligible dependents or employment status. Failure to do so, will result in repayment of incorrect benefit payments to Macomb County.

______________________ ______________

Signature of Subscriber Date

Section 5: To be completed by Benefits Clerk

Date of Divorce: ______________________ Date of EDRO Received: ______________

______________________________ ______________________
HR Signature Approval Date

Ent'd/IFAS: ______________________

Hearing: Group # / Suffix # ______________ Entered / Delivered ______________

Vision: Group # / Suffix # ______________ Entered / Delivered ______________

Dental: Group # / Suffix # ______________ Entered / Delivered ______________

Remarks: ____