

**BLUE CROSS/BLUE SHIELD AND DELTA DENTAL  
ENROLLMENT/CHANGE FORM**

**Section I - Select action to be taken:**

Enrollment:    \_\_\_ Birth of Child            \_\_\_ Marriage/Divorce            \_\_\_ New Hire  
 Separation:    \_\_\_ Retirement                    \_\_\_ Resignation                \_\_\_ Other  
 Change:        \_\_\_ Name                            \_\_\_ Address                      \_\_\_ Add/remove covered members

<p><b>HR ONLY Transfer:</b>                  From _____                  To _____</p>
---

Effective date of action: \_\_\_\_\_ (New hires are effective the first of the month following date of hire.)

**Section II – Enrollment (check box to enroll)**

Blue Cross/Blue Shield Community Blue PPO  ___ Health/Vision/Hearing	Delta Dental of Michigan  ___ Dental	Blue Cross/Blue Shield A-80Vision Plan  ___ Vision/Hearing (select only if waiving the health insurance)	Health Insurance Waiver Incentive Program  ___ Health Waiver Separate Enrollment Form
---	---	--	---

**Section III – Employee**

Subscriber Name:		Social Security No:	
Address:		City/State/Zip:	
Phone:	Marital Status:	Sex:	Date of Hire:                      Date of Birth:

**Section IV - List all person(s) to be added or removed from coverage.**

Name (Last, First, MI)	Social Security #	Birth Date	M/F	Check One		Beneficiary Update
				Add	Remove	
Spouse						
Dep. 1						Do you need to update your beneficiary forms for life and/or retirement?  ___ Yes ___ No
Dep. 2						
Dep. 3						
Dep. 4						

**If you are adding/removing a spouse and/or dependents, a copy of your marriage license and dependent(s) birth certificate are needed for adding and divorce decree for removing. (COPY ONLY) is required.** Any changes in covered family members, if due to birth of a child, marriage, divorce, death, dependent obtains own coverage or no longer meets eligibility, must be communicated to the **Human Resources within 30 days of the effective date** to ensure dependents are removed and/or added to coverage without a delay and to avoid being liable for insurance claims and college health and dental premiums paid.

**COBRA NOTIFICATION ADDRESS:** \_\_\_\_\_  
 Complete only if you are discontinuing coverage for a covered member.

You can enroll or change your Flexible Spending if you have a change of status. Refer to the Flexible Spending Summary Plan Description for eligibility at <https://deltanet.delta.edu/myintranet/finance/FlexibleSpending.PDF> You must make a new election within **30 days** of your qualified change in family status for it to be effective for the remainder of the year.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HUMAN RESOURCES OFFICE USE**

BENEFIT	Suffix	Benefit Effective Date	Benefit Separation Date	Single	Two Party	Family	Datatel Process Date	Incentive	COBRA Processed
HEALTH									
DENTAL	0001								
VISION/HEARING									