MACOMB COUNTY
Human Resources and Labor Relations Department
1 South Main Street 6th Floor, Mount Clemens, MI 48043 ▪ Phone (586)469-5280 ▪ Fax (586)469-6974

Macomb County Change Form

Type: ☐ Enrollment ☐ Change ☐ Termination **Status:** ☐ Active ☐ COBRA

Effective Date for Medical/Vision: ____________ Dental Effective Date: ____________

Section 1: General Information – Please Print Clearly

Employee's Name: Last, First, MI ____________

Gender ☐ Male ☐ Female

Birth Date ____________

Social Security Number ____________

Address: Street, City, State, Zip ____________

Marital Status ☐ Single ☐ Married

Phone Number: ____________ **Employee ID #:** ____________

Election will be processed based on information provided on this form

Section 2: Insurance Information

*** Must select Primary Care Physician (PCP) or office**

Medical	Vision	Dental
☐ BC/BS PPO	☐ SVS (only available w/BCBS PPO or BCN)	☐ Delta Dental
☐ HAP – HMO*	☐ HAP (only available w/HAP)	☐ Golden Dental*
☐ BlueCare Network (BCN)*	☐ Waive	☐ Waive
☐ Insurance Waiver		
☐ Ineligible for medical		

Section 3: Change(s)

Event: ☐ Marriage ☐ Birth ☐ Guardianship ☐ Divorce ☐ Death ☐ Other

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

☐ Add Spouse ☐ Delete Spouse ☐ Add Dependent ☐ Delete Dependent ☐ Cancel Contract

ALL INSURANCE CHANGES MUST BE MADE WITHIN 30 DAYS OF THE EVENT

Self

Primary Care Physician*: ____________ Provider Code: ____________

Dental Office*: ____________

Spouse

Last, First, MI ____________

Gender ☐ Male ☐ Female

Birth Date ____________

Social Security Number ____________

Primary Care Physician *: ____________ Provider Code: ____________

Dental Office*: ____________

	Last, First, MI	Gender	Birth Date	Social Security Number
Dependent	______	☐ Male ☐ Female	______	______

Primary Care Physician *: Provider Code:

Dental Office*: ______

	Last, First, MI	Gender	Birth Date	Social Security Number
Dependent	______	☐ Male ☐ Female	______	______

Primary Care Physician *: ______ Provider Code: ______

Dental Office*: ______

SECTION 4: Authorization Signature

I understand that I must notify Human Resources and Labor Relations within 30 days of any possible change in status of adding or deleting eligible dependents. Failure to do so will result denial of the enrollment or in repayment of incorrect benefit payments to Macomb County.

I understand that the submission of false or misleading information or the omission of material on this form may result in rejection of my enrollment or change retroactive to the requested effective date.

I understand that this request may not change my current coverage until all proper documentation has been verified.

______ Signature of Subscriber

______ Date

Section 5: To be completed by Human Resources and Labor Relations Department

Date of Divorce: ______ Date of EDRO Received: ______

Ent'd/ One Solution: ______ Union: ______

______ HRLR Signature Approval

______ Date

COBRA Administration: **Qualifying Event Date:** ______

Medical Plan: ______ Entered Date: ______

Vision Plan: ______ Entered Date: ______

Dental Plan: ______ Entered Date: ______

Letter Sent: ______ Compliance Log: ______

Remarks: ______

Entered by: ______