



Michigan Education  
Special Services Association  
1475 Kendale Blvd., P.O. Box 2560,  
East Lansing, Michigan 48826-2560  
888 / 888-4167

# GROUP APPLICATION TO MESSA CARRIERS

PLEASE PRINT CLEARLY

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ MALE  FEMALE

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

COUNTY \_\_\_\_\_ E-MAIL \_\_\_\_\_

**DEPENDENT INFORMATION:** INCLUDE SPOUSE, UNMARRIED CHILDREN UNDER THE AGE OF 25, IF YOU PROVIDE MAJORITY OF SUPPORT AND SPONSORED DEPENDENTS. SEE THE ENROLLMENT INFORMATION BROCHURE FOR THE SPECIFIC DEFINITION OF ELIGIBLE DEPENDENTS IF NECESSARY, INCLUDE ADDITIONAL DEPENDENT INFORMATION ON A SEPARATE SHEET OF PAPER AND ATTACH TO THIS APPLICATION.

Name (Last) (First) (Middle)	Social Security Number	Birth Date	Sex	<input type="checkbox"/> College Student <input type="checkbox"/> SRS Dependent <input type="checkbox"/> Disabled	<input type="checkbox"/> Sponsor <input type="checkbox"/> Maj. Spl.
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> College Student <input type="checkbox"/> SRS Dependent <input type="checkbox"/> Disabled	<input type="checkbox"/> Sponsor <input type="checkbox"/> Maj. Spl.
Dependent			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> College Student <input type="checkbox"/> SRS Dependent <input type="checkbox"/> Disabled	<input type="checkbox"/> Sponsor <input type="checkbox"/> Maj. Spl.
Dependent			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> College Student <input type="checkbox"/> SRS Dependent <input type="checkbox"/> Disabled	<input type="checkbox"/> Sponsor <input type="checkbox"/> Maj. Spl.
Dependent			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> College Student <input type="checkbox"/> SRS Dependent <input type="checkbox"/> Disabled	<input type="checkbox"/> Sponsor <input type="checkbox"/> Maj. Spl.

## BENEFICIARY DESIGNATION

**PRIMARY BENEFICIARY** (Enter full name) \_\_\_\_\_ Relationship \_\_\_\_\_

If living, otherwise; **SECONDARY BENEFICIARY** (Enter full name) \_\_\_\_\_ Relationship \_\_\_\_\_

**FOR EMPLOYER'S USE ONLY. EMPLOYER MUST COMPLETE FOR APPLICATION PROCESSING.**

JOB CODE \_\_\_\_\_ ANNUAL SALARY \_\_\_\_\_ DATE OF HIRE \_\_\_\_\_

ACCUMULATED SICK DAYS \_\_\_\_\_ EMPLOYEE JOB TITLE \_\_\_\_\_

EMPLOYED FULL TIME \_\_\_\_\_ EMPLOYED PART-TIME: HRS PER WEEK \_\_\_\_\_

EMPLOYER'S INITIALS & DATE \_\_\_\_\_ EMPLOYER'S STAMP \_\_\_\_\_

NEW ENROLLEE \_\_\_\_\_ REHIRE /REINSTATE \_\_\_\_\_ TRANSFER TO NEW JOB \_\_\_\_\_

## NEGOTIATED BENEFIT PROGRAMS - Non PAK Coverage

**LIFE:** Effective Date \_\_\_\_\_

**AD&D:** Effective Date \_\_\_\_\_

**Dependent Life:** Effective Date \_\_\_\_\_

**Optional Life & AD&D:** Effective Date \_\_\_\_\_ Volume \$ \_\_\_\_\_

**LTD:** \* Effective Date \_\_\_\_\_

**STD:** Effective Date \_\_\_\_\_

Weekly Benefit \$ \_\_\_\_\_

Begins:  8th Day  29th Day

**VISION:** Effective Date \_\_\_\_\_

DISTRIBUTION: WHITE - MESSA YELLOW - EMPLOYER PINK - EMPLOYEE

## A HEALTH COVERAGE

All health coverages except MESSA PAK B include \$5,000 Basic Term Life, AD&D and major medical coverage.

- PAK A  PAK B  Non-PAK Health Coverage (Fill in health plan requested.) \_\_\_\_\_
- Member  Member & Spouse  Member & Child  Full Family

Do you have dental coverage through another source?  YES  NO

(Check with your employer's business office for this rate.) \$ \_\_\_\_\_

## B LIFE COVERAGE

\$5,000 Group Basic Term Life Insurance & AD&D (available only if not enrolling in MESSA Health Coverage)

\$2,000 Group Dependent Life Insurance on spouse & each eligible child

Complete the following health questions if you enroll for Survivor Income or Supplemental Term Life Insurance.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Circle any/all of the following six conditions that you have been diagnosed with or treated for in the past two years:

- Cancer Diabetes Heart Disease High Blood Pressure Rheumatic Fever Tumor

## C GROUP SURVIVOR INCOME INSURANCE

Monthly benefits for eligible dependents are \$400 for spouse and \$200 for children.

Do you want this coverage?  YES  NO

\$ \_\_\_\_\_

## D GROUP SUPPLEMENTAL TERM LIFE INSURANCE

\$10,000 + AD&D  \$20,000 + AD&D  \$30,000 + AD&D  \$40,000 + AD&D

\$ \_\_\_\_\_

## E GROUP SHORT TERM DISABILITY INCOME INSURANCE\*

Weekly Benefit \$ \_\_\_\_\_ Benefit Begins:  8TH DAY  29TH DAY

\$ \_\_\_\_\_

## F GROUP LONG TERM DISABILITY INCOME INSURANCE\*

Monthly Benefit \$ \_\_\_\_\_  OPTION 1  OPTION 2

\$ \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_

TOTAL CONTRIBUTION \$ \_\_\_\_\_

Blue Cross and Blue Shield of Michigan issues the group major medical expense coverage under a group agreement with MESSA. BCS issues medical expense coverage under group policy number SMM29194. Life Insurance Company of North America (LINA) insures all other listed coverages under group policy numbers with MESSA. I apply for the coverages elected herein for which I am eligible. I understand that any coverage elected is not effective until approved by MESSA's carriers and the first contribution for the cost of such coverages is paid. I further understand that it is my responsibility to notify MESSA of any change in my employment status or any dependent's eligibility for coverage. I consent to the release to and by BCBSM and BCS of all medical, hospital and other information necessary for BCBSM or BCS business purposes. I also consent to the release to and by MESSA of all medical, hospital and other information necessary for MESSA business purposes. A photographic copy of this application shall be as valid as the original.

Signature of applicant **X**

Date \_\_\_\_\_