MESSA
Good health. Good business. Great schools.

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1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
Questions? Call 888.888.4167
Fax 517.203.2914

Member Change Form

This form is designed to make any of the changes listed below. Please fill out completely, sign and return to your employer. The signed form **must be submitted within 31 days** of the requested qualifying event or change to ensure timely processing. Forms received after 31 days of the actual event will be effective 1st of the month following MESSA approval.

MESSA Member Information *(Required)*

SSN or MESSA ID#: _____

CURRENT Name and Address Information			NEW Name and Address Information		
First Name	Last Name		First Name	Last Name	
Address		Apt. #	Address		Apt. #
City	State	Zip Code	City	State	Zip Code
Home Phone ( )			Home Phone ( )		
Email			Email		

Effective Date: _____

Important Reminder: *Do you need to change or update your life insurance beneficiary? You can obtain a **Beneficiary Designation Form** online at www.messa.org or by calling MESSA at 888.888.4167.*

Change Code(s) *(check all that apply)*

Qualifying Events: Events that qualify you to make changes to your coverage outside of normal Open Enrollment period. Social Security Numbers are required for all dependents. Please submit for newborns when issued.

- ☐ 1 **Marriage:** ***Date of Marriage:*** _____ To add a spouse or dependent(s) complete Sections 1 & 3
- ☐ 2 **Birth:** To add a newborn complete Section 1.
- ☐ 3 **Adoption:** To add an adopted child complete Section 1. Provide copy of legal documents. Provide copy of *Order for Purposes of Adoption*.
- ☐ 4 **Legal Guardianship:** To add a dependent(s) complete Section 1. Provide copy of legal documents.
- ☐ 5 **Sponsored Dependent:** Complete Section 1 to add. There is an additional cost for this coverage and MESSA requires IRS verification.
- ☐ 6 **Divorce:** ***Date of divorce:*** _____ To delete a spouse complete Sections 1 & 3
- ☐ 7 **Other Eligible Dependents:** To add an eligible dependent not listed above complete Section 1.

Other Changes:

- ☐ 8 **Delete Dependent:** To delete dependent(s) complete Section 1.
- ☐ 9 **Cancel Variable Options:** To cancel variable options complete Section 2. *Cancellation of non-PAK Medical requires a Member Application.*
- ☐ 10 **Dental Coordination of Benefits:** To change dental coverage complete Section 3.
- ☐ 11 **Legal Name Change:** To change name other than through marriage or divorce requires legal documentation.

Section 1: Dependents *(All information requested below is required to add a dependent.)*

First Name	Last Name	Gender M F	Date of Birth (mm/dd/yyyy)	Social Security #	Relationship to Member	Change Code (See Above)	Requested Effective Date (mm/dd/yyyy)
		☐ ☐					
		☐ ☐					
		☐ ☐					
		☐ ☐					

Section 2: CANCEL Variable Options

Effective Date: _____

- ☐ Optional Short Term Disability (STD)
- ☐ Optional Long Term Disability (LTD)
- ☐ Optional Dependent Life
- ☐ Optional Survivor Income Insurance (SII)
- ☐ Optional Hospital Confinement (HCI)
- ☐ Optional Supplemental Term Life
- ☐ Optional Basic Term Life (BTL)

Note: if you are enrolled in Non-PAK Medical, you may ***not*** cancel BTL.

Section 3: Dental Coordination of Benefits

Effective Date: _____

Do you, your spouse or dependents have dental coverage through another source? ☐ Yes ☐ No Who is covered through the source? ☐ Self ☐ Spouse ☐ Dependents

Employee Signature	Date
Authorized Employer Signature and Stamp	Date