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.

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: All changes submitted on this form outside of open enrollment must be due to a qualifying event. *Social Security Numbers are required for all dependents.

- ☐ 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. Remember to submit Social Security Numbers for newborns when issued.
- ☐ 3 **Adoption:** To add an adopted child complete Section 1.
- ☐ 4 **Legal Guardianship:** To add a dependent(s) complete Section 1.
- ☐ 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 and any applicable dependents 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 or delete a dependent. Only list the dependents affected by the indicated change code.)*

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