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
www.messa.org

Member Application for MESSA Benefits

MEMBER INFORMATION

Please PRINT clearly or TYPE

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)	MALE	FEMALE	FIRST NAME	MI	LAST NAME
		☐	☐			

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE	HOME PHONE	E-MAIL
					( )	

DEPENDENT INFORMATION

Please refer to your MESSA Plan Coverage Booklet at *www.messa.org* for complete eligibility guidelines. If necessary, include additional dependent information on a separate sheet of paper and attach to this application.

SPOUSE		SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)	GENDER
				MALE ☐ FEMALE ☐
Dependent	**Relationship to Member**			
				MALE ☐ FEMALE ☐
Dependent	**Relationship to Member**			
				MALE ☐ FEMALE ☐
Dependent	**Relationship to Member**			
				MALE ☐ FEMALE ☐

COVERAGE INFORMATION

NOTE: To designate or change Life Insurance beneficiaries you must submit a ***Beneficiary Designation Form***, available online at ***www.messa.org*** or by calling MESSA at 888.888.4167.

A HEALTH COVERAGE

All health coverage includes $5,000 Basic Term Insurance, AD&D and major medical coverage

☐ PAK A ☐ PAK B ☐ PAK C ☐ OTHER PAK/BUNDLE_____ ☒ Non-PAK HEALTH COVERAGE (see employer for plan choices): 10/20 drug plan $_____

☐ MEMBER ☐ MEMBER & SPOUSE ☐ MEMBER & CHILD ☐ FULL FAMILY **Do you, your spouse or dependents have dental coverage through another source?** ☐ Yes ☐ No **Who is covered?** ☐ Self ☐ Spouse ☐ Dependents

B OPTIONAL LIFE COVERAGE

Please refer to the back of this form for Life Insurance rates.

☐ **$5,000 BASIC TERM LIFE INSURANCE and AD&D** ***Note:*** *Available only if not enrolling in MESSA Health Coverage.* $_____

☐ **$2,000 DEPENDENT LIFE INSURANCE ON SPOUSE & EACH ELIGIBLE CHILD** $_____

☐ **SUPPLEMENTAL TERM LIFE INSURANCE** ☐ **$10,000 + AD&D** ☐ **$20,000 + AD&D** ☐ **$30,000 + AD&D** ☐ **$40,000 + AD&D** $_____

Important Note:
Optional Insurance is not available at all school districts. Please contact your school business office to determine your eligibility to elect any optional insurance.

C GROUP SURVIVOR INCOME INSURANCE

Please refer to the back of this form for rates.

☐ **MONTHLY BENEFITS FOR ELIGIBLE DEPENDENTS ARE $400 FOR SPOUSE AND $200 FOR CHILDREN** $_____

D OPTIONAL DISABILITY INCOME INSURANCE

Please refer to the back of this form for rates.

☐ **SHORT TERM DISABILITY INCOME INSURANCE** **Weekly Benefit:** $_____ **Benefit Begins:** ☐ **8th Day** ☐ **29th Day** $_____

☐ **LONG TERM DISABILITY INCOME INSURANCE** **Monthly Benefit:** $_____ ☐ **Option 1** ☐ **Option 2** $_____

FOR EMPLOYER'S USE ONLY — EMPLOYER MUST COMPLETE FOR APPLICATION PROCESSING

NEGOTIATED BENEFIT PROGRAMS - Non-PAK COVERAGE **EFFECTIVE DATE:**

☐ **LIFE** Volume $
☐ **AD&D** Volume $
☐ **DEPENDENT LIFE**
☐ **OPTIONAL LIFE and AD&D** Volume $
☐ **STD** Weekly Benefit $
Begins: ☐ 8th Day ☐ 29th Day
☐ **LTD**
☐ **VISION:** ☐ Single ☐ Full Family ☐ 2 Person
☐ **DENTAL:** ☐ Single ☐ Full Family ☐ 2 Person
DENTAL COB? ☐ Yes ☐ No

JOB CODE	EMPLOYEE JOB TITLE	DATE OF HIRE

ACCUMULATED SICK DAYS:
ANNUAL SALARY

☐ **EMPLOYED FULL TIME**
☐ **EMPLOYED PART-TIME:** **HRS PER WEEK**
☐ **NEW ENROLLEE**
☐ **REHIRE/REINSTATE**
☐ **TRANSFER TO NEW JOB**

EMPLOYER'S INITIALS & DATE	EMPLOYER'S STAMP OR GROUP NUMBER

EFFECTIVE DATE	TOTAL CONTRIBUTION $ 0.00

Blue Cross and Blue Shield of Michigan issues the group major medical expense coverages under a group agreement with MESSA. BCS issues medical expense coverages 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 coverage 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 coverage 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 or 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	DATE (MM-DD-YYYY)
X	