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

messa ABC
ACCOUNT-BASED CHOICES

Member Application for MESSA ABC 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 ☐

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

☐ MESSA ABC PLAN 1 ☐ MESSA ABC PLAN 2 ☐ MESSA ABC PLAN 3 ☐ PAK ☐ Non-PAK. $ _____

☐ 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

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

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

☐ $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 $ _____

EFFECTIVE DATE

TOTAL CONTRIBUTION $ 0.00

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 | EMPLOYED FULLTIME | EMPLOYED PART-TIME - HRS PER WEEK

ANNUAL SALARY | NEW ENROLLEE | REHIRE/REINSTATE | TRANSFER TO NEW JOB

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

- I accept the terms of the HealthEquity HSA Custodial Agreement which is available by clicking on "Forms and Documents" in the Resource Center on www.healthyequity.com
- In compliance with the USA PATRIOTS act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established.

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

X

DATE (MM-DD-YYYY)