# If you <u>don't want</u> Medicare Advantage coverage:

*How to opt out of Medicare Plus Blue℠ Group PPO coverage*

The Michigan Public School Employees' Retirement System offers a Medicare Plus Blue ℠ Group PPO plan. If you decide that you do not want to retain coverage under the Michigan Public School Employees' Retirement System Medicare Advantage plan, or if you have other primary coverage and do not want to be enrolled in the Medicare Advantage plan, complete the form on the other side of this page, sign where requested and send it to the ORS using the address or fax number below.

## *Important: Only Return This Form If…*

- You are currently enrolled in a Medicare Advantage plan or Medicare Prescription Drug (Part D) plan that is not part of the Michigan Public School Employees' Retirement System **<u>and</u>** wish to remain in that plan.
- You do not want to be enrolled in the Medicare Advantage plan offered through the Michigan Public School Employees' Retirement System.

If you are the contract holder and decide to not enroll in the Medicare Advantage plan, you and your dependents on your medical contract (all of your Medicare-eligible and non-Medicare eligible dependents) will be removed. You and your dependents will no longer have medical or prescription drug coverage through the Michigan Public School Employees' Retirement System.

Please make sure you complete the form in its entirety. The ORS may contact you for verification.

Return the form to:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

OR

Office of Retirement Services
Fax: (517) 284-4416

If you wish to continue your coverage through the Michigan Public School Employees' Retirement System and receive Medicare Advantage coverage, you must contact ORS with your Medicare number and effective dates for Parts A and B once you receive your red, white and blue Medicare card. If the ORS does not receive your Medicare number and effective dates for Parts A and B, your Medicare Advantage enrollment will not be processed, and your retirement system coverage will end.

If you have questions about enrollment, call the ORS at 1-800-381-5111 Monday through Friday from 8:30 a.m. to 5 p.m., Eastern Time. TTY users call 711.

**Michigan Public School Employees' Retirement System Medicare Plus Blue Group PPO plan**

**OPT-OUT FORM**

**If you wish to decline coverage, complete all sections below and return to ORS.** (Please print)

| | |
|---|---|
| Name: | Relationship to Contract Holder: |
| Contract Holder SSN: | Medicare ID No.: |
| Medicare SSN (if different from Contract Holder): | |
| Medicare Part A Effective Date:____/____/____ | Medicare Part B Effective Date:____/____/____ |
| Telephone No.: | Email Address: |
| Permanent Home Address: | |
| Mailing Address (if different than above): | |

**Important***: You can only be enrolled in one Medicare plan at a time. If you are already enrolled in a Medicare Advantage plan or an individual Medicare Prescription Drug (Part D) plan, or if you are covered through your spouse's Medicare Advantage or Medicare Prescription Drug plan, you must decide which plan you wish to keep. If you provide your Medicare information to ORS, they will request to enroll you in the Michigan Public School Employees' Retirement System Medicare Advantage plan and Medicare will automatically cancel your other Medicare coverage.*

## Check below if you wish to opt out of Medicare Advantage coverage:

**I decline coverage for myself and I understand this will result in the termination of all medical and prescription drug coverage provided by the Michigan Public School Employees' Retirement System.**

**Important:** If you are the contract holder and you decline coverage, you and your dependents will be removed from medical and prescription drug coverage through the Michigan Public School Employees' Retirement System.

*Once you or your representative have checked the box above and provided any requested information, please complete the information below, sign, and date.*

**X**_____ **(____)**_____

**Signature** **Date signed** **Daytime phone number**

***If you are signing as the contract holder's authorized representative, please complete the section below.***

*The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this opt-out form and 2) documentation of this authority is available upon request.*

| | |
|---|---|
| _____ **Name of representative** | **(_____)**_____ **Daytime phone number** |
| _____ **Address** | _____ **Relationship to retiree** |