Department of Management & Budget
Office of Retirement Services
www.michigan.gov/ors (800) 381-5111
P.O. Box 30171
Lansing MI 48909-7671

Name and/or Address Change Request

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN
MAILING ADDRESS	DATE OF BIRTH
CITY, STATE, ZIP CODE	DAYTIME TELEPHONE ( )

Use this form to change your name and/or address.

Note: If you currently receive a pension payment by mail, this change may not affect your next pension. Your change(s) will become effective the month after we receive your request.

Name Change

If you are changing your name, please enter your new name here. Please provide legal documentation of your name change such as a copy of a marriage certificate or Social Security card.

NEW LAST NAME	FIRST NAME	M.I.

Address Change

If you are changing your address, please enter your new address here.

MAILING ADDRESS			TELEPHONE
CITY	STATE	ZIP	EFFECTIVE DATE OF CHANGE

Certification

This form must be signed before it can be processed. If a member is unable to sign, the endorser must enclose a copy of his or her authorization of guardianship, power of attorney, or conservatorship.

APPLICANT SIGNATURE DATE

MESSA.
www.messa.org

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

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	
First Name	Last Name
Address	
City / State / Zip Code	
County	Daytime Phone ( )
E-mail	

NEW Name and Address Information	Effective Date:
First Name	Last Name
Address	
City / State / Zip Code	
County	Daytime Phone ( )
E-mail	

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.

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

Other Changes:

- ☐ ❽ **Delete Dependent:** To delete dependent(s) complete Section 1.
- ☐ ❾ **Cancel Variable Options:** To cancel variable options complete Section 2. *Cancellation of non-PAK Medical requires a Member Application.*
- ☐ ❿ **Dental Coordination of Benefits:** To change dental coverage complete Section 3.
- ☐ ⓫ **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	Gender 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 other source? ☐ Self ☐ Spouse ☐ Dependents

Employee Signature	Date
Authorized Employer Signature and Stamp	Date

BCW-4

EMPLOYEE'S WITHHOLDING CERTIFICATE FOR CITY OF BATTLE CREEK INCOME TAX

IF YOU RESIDE IN THE CITY PLACE AN "R" IN THE BOX. IF YOU RESIDE OUTSIDE THE CITY PLACE AN "N" IN THE BOX: ☐

1. Print Full Name	Social Security No.	Office, Plant, Dept.	Employee ID Number
2. Address, Number and Street	City, Township or Village where you reside	State	Zip Code

3. Predominant Place of Employment Print name of each city where you work for this employer and circle closet % of total earnings in each	City	Under 25% ☐ 40% ☐ 60% ☐ 80% ☐ 100% ☐
	City	Under 25% ☐ 40% ☐ 60% ☐ 80% ☐ 100% ☐

YOUR WITHHOLDING EXEMPTIONS: Check blocks which apply	4. Exemptions for YOURSELF ☐Blind ☐65 & Over ☐Deaf ☐Disabled	Enter Total number	
	5. Exemptions ☐SPOUSE ☐Blind ☐65 & Over ☐Deaf ☐Disabled	Enter total number	
	6. (a) Exemptions for your children — Number; 6. (b) Exemptions for your other dependents — Number	Enter Total 6. (a) & (b)	
	7. Add the number of exemptions which have claimed on lines 4, 5 & 6 above		

EMPLOYEE: File this form with your employer. Otherwise he must withhold CITY OF BATTLE CREEK income tax from your earnings without exemptions.

EMPLOYER: Keep this certificate with your records. If the information submitted by the employee is not believed to be true, correct and complete advise the City.

I certify that the information submitted on this certificate is true, correct and complete to the best of my knowledge and belief.

8. Date 20	Signature

LINE 3 INSTRUCTIONS - If you work for this employer in more than two cities or communities, print names of two cities or communities where you perform the greatest percent of your work. Circle the closest percent of total earnings for work done or services rendered in each city or community listed. The estimated percent of total earnings from this employer for work done or services performed within taxing cities (line 3 on other side) is for withholding purposes only. In determining final tax liability this estimate is subject to substantiation and audit.

DEPENDENTS - To qualify as your dependent (line 6 on other side), a person (a) must receive more than one-half of his or her support from you for the year, and (b) must have less than $1500 (Subject to Change) gross income during the year and (c) must not be claimed as an exemption by such person's husband or wife, and (d) must be a citizen or resident of the United States or a resident of Canada, Mexico, the Republic of Panama or the Canal Zone (this does not apply to an alien child legally adopted by and living with a United States citizen abroad), and (e) must (1) have your home as his or her principal residence and be a member of your household for the entire year, or (2) be related to you as follows:

Your son or daughter (including legally adopted children), grand children, stepson, stepdaughter, son-in-law, or daughter-in-law;
Your father, mother grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
Your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law, or sister-in-law;
Your uncle, aunt, nephew, or niece (but only if related by blood).

CHANGES IN EXEMPTIONS - You should file a new certificate at any time if the number of your exemptions INCREASES.

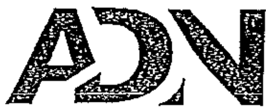
You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES for any of the following reasons:

(a) Your wife (or husband) for whom you have been claiming exemption is divorced or legally separated, or claims her (or his) own exemption on a separate certificate.
(b) The support of a dependent for whom you claimed exemption is taken over by someone else, so that you can no longer expect to furnish more than half the support for the year.
(c) You find that a dependent for whom you claimed exemption will receive $1500 (Subject to Change) or more of income of his own during the year.

OTHER DECREASES in exemption, such as death of a wife or a dependent, do not affect your withholding until the next year, but require the filing of a new certificate by December 1 of the year in which death occurs.

CHANGE OF RESIDENCE - You must file a new certificate within 10 days after you change your residence from or to a taxing city.

CHANGES IN EMPLOYMENT - You must file a new certificate by December 1 of each year if your Line 3 estimate of the percent of work done or services to be rendered in cities levying an income tax will change for the ensuing year.



LAKEVIEW SCHOOL DISTRICT
DENTAL ENROLLMENT FORM

Eligibility/Change/Termination Report

General Information – Employee

Name (Last) (First) (Middle) Sex Birth Date Social Security #

Address (Street) City State Zip Code

Occupation Hire Date Effective Date

Section 2 – Dependent Information

Name (Last)	(First)	(Middle)	Sex	Date of Birth	Relationship	Effective Date

Is there a court order requiring coverage for any dependent in the case of divorced or legally separated parents? ——Yes —— No

Section 3 – Change/Correction

A. Name Change

	Last Name	First Name	Social Security #	Effective Date
Employee: From: To:				
Dependents: From: To:				

B. Termination of Benefits
Employee Effective Date of Termination: ____________________

Dependent Effective Date of Termination: ____________________

Spouse: ____________________

Dependent(s): ____________________

C. Additional Coverage - Will this enrollment result in coverage under more than one dental program for you or your spouse? Yes__________ No__________

Signature______________________________Date______________

INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

EMPLOYER (GROUP) NAME Lakeview School District (Option 1)				GROUP NO. 51506 0001 01 ☐ Teachers 51506 0001 02 ☐ Secretaries 51506 0001 03 ☐ Food Services 51506 0001 04 ☐ Custodial / Maintenance 51506 0001 99 ☐ Cobra
EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER — —	GENDER ☐ Male ☐ Female	CONTRACT TYPE REQUESTED ☐ Single (S) ☐ Employee + 1 (L) ☐ Family [Employee + 2 or more] (F)		
EFFECTIVE DATE OF COVERAGE *OR* CHANGE	DATE OF HIRE			

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY ____________________

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: X ____________________________________ DATE: ____________________

EMPLOYER SIGNATURE: X ____________________________________ DATE: ____________________

www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C.
1200 Route 46 West
Clifton, NJ 07013

Toll Free: (800) 672-7723

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