MESSA
www.messa.org

Michigan Education
Special Services Association
1475 Kendale Blvd., P.O. Box 2560,
East Lansing, Michigan 48826-2560
888 / 888-4167

GROUP APPLICATION TO MESSA CARRIERS

PLEASE PRINT CLEARLY

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE	
LAST NAME	FIRST	MIDDLE	MALE / FEMALE
STREET ADDRESS	CITY	STATE	ZIP
COUNTY	E-MAIL		

DEPENDENT INFORMATION: INCLUDE SPOUSE, UNMARRIED CHILDREN UNDER THE AGE OF 25, IF YOU PROVIDE MAJORITY OF SUPPORT AND SPONSORED DEPENDENTS. SEE THE ENROLLMENT INFORMATION BROCHURE FOR THE SPECIFIC DEFINITION OF ELIGIBLE DEPENDENTS IF NECESSARY, INCLUDE ADDITIONAL DEPENDENT INFORMATION ON A SEPARATE SHEET OF PAPER AND ATTACH TO THIS APPLICATION.

Name (Last) (First) (Middle)	Social Security Number	Birth Date	Sex	
Spouse			☐ M ☐ F	☐ College Student ☐ Sponsor ☐ IRS Dependent ☐ Maj. Spt. ☐ Disabled
Dependent			☐ M ☐ F	☐ College Student ☐ Sponsor ☐ IRS Dependent ☐ Maj. Spt. ☐ Disabled
Dependent			☐ M ☐ F	☐ College Student ☐ Sponsor ☐ IRS Dependent ☐ Maj. Spt. ☐ Disabled
Dependent			☐ M ☐ F	☐ College Student ☐ Sponsor ☐ IRS Dependent ☐ Maj. Spt. ☐ Disabled
Dependent			☐ M ☐ F	☐ College Student ☐ Sponsor ☐ IRS Dependent ☐ Maj. Spt. ☐ Disabled

BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY (Enter full name)

______________________ **Relationship** ______________

If living, otherwise; **SECONDARY BENEFICIARY** (Enter full name)

______________________ **Relationship** ______________

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

JOB CODE: ANNUAL SALARY DATE OF HIRE

ACCUMULATED SICK DAYS: EMPLOYEE JOB TITLE

☐ EMPLOYED FULL TIME ☐ EMPLOYED PART-TIME: HRS PER WEEK ________

EMPLOYER'S INITIALS & DATE EMPLOYER'S STAMP

☐ NEW ENROLLEE ☐ REHIRE / REINSTATE ☐ TRANSFER TO NEW JOB

NEGOTIATED BENEFIT PROGRAMS – Non PAK Coverage

☐ **LIFE: Effective Date** ________

☐ AD&D Effective Date ________

☐ Dependent Life Effective Date ________

☐ Optional Life & AD&D Effective Date ________ Volume $

☐ **LTD:* Effective Date** ________

☐ **STD: Effective Date** ________

Weekly Benefit $ ________

Begins: ☐ 8th Day ☐ 29th Day

☐ **VISION: Effective Date** ________

A HEALTH COVERAGE

All health coverages except MESSA PAK B include $5,000 Basic Term Life, AD&D and major medical coverage.

☐ PAK A ☐ PAK B ☐ Non-PAK Health Coverage (Fill in health plan requested.) ________

☐ Member ☐ Member & Spouse ☐ Member & Child ☐ Full Family

Do you have dental coverage through another source? ☐ YES ☐ NO

(Check with your employer's business office for this rate.) $ ________

B LIFE COVERAGE

☐ $5,000 Group Basic Term Life Insurance & AD&D (available only if not enrolling in MESSA Health Coverage) $ ________

☐ $2,000 Group Dependent Life Insurance on spouse & each eligible child $ ________

Complete the following health questions if you enroll for Survivor Income or Supplemental Term Life Insurance.

Height_____ Weight_____ Circle any/all of the following six conditions that you have been diagnosed with or treated for in the past two years:

Cancer Diabetes Heart Disease High Blood Pressure Rheumatic Fever Tumor

C GROUP SURVIVOR INCOME INSURANCE

Monthly benefits for eligible dependents are $400 for spouse and $200 for children.

Do you want this coverage? ☐ YES ☐ NO $ ________

D GROUP SUPPLEMENTAL TERM LIFE INSURANCE

☐ $10,000 + AD&D ☐ $20,000 + AD&D ☐ $30,000 + AD&D ☐ $40,000 + AD&D $ ________

E GROUP SHORT TERM DISABILITY INCOME INSURANCE*

Weekly Benefit $________ Benefit Begins: ☐ 8TH DAY ☐ 29TH DAY $ ________

F GROUP LONG TERM DISABILITY INCOME INSURANCE*

Monthly Benefit $________ ☐ OPTION 1 ☐ OPTION 2 $ ________

EFFECTIVE DATE	TOTAL CONTRIBUTION
	$ ________

Blue Cross and Blue Shield of Michigan issues the group major medical expense coverage under a group agreement with MESSA. BCS issues medical expense coverage under group policy number SMM29194. Connecticut General insures all other listed coverages under group policy numbers 57200 and 57220 with MESSA. I apply for the coverages 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 coverages 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 and 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 ________

DISTRIBUTION: WHITE - MESSA YELLOW - EMPLOYER PINK - EMPLOYEE

MES-4435 Rev. 8/04

Contribution Rates for Optional Coverages

All rates shown below are monthly rates.

The Group Dependent Life Insurance and/or the coverages below are available only in **ADDITION** to a MESSA health insurance plan **OR** the Group Basic Term Life Insurance.

A

Check with your employer's business office for this rate.

B LIFE COVERAGE

	MONTHLY RATE
$5,000 Group Basic Term Life Insurance	$ 2.36
$2,000 Group Dependent Life Insurance on spouse & each child	$ 1.48

C GROUP SURVIVOR INCOME INSURANCE

Age is determined as of previous July 1

Age	MONTHLY RATE
Under age 30	$ 3.18
Age 30 - 34	4.20
Age 35 - 39	5.88
Age 40 - 44	8.90
Age 45 - 49	12.44
Age 50 - 54	15.80
Age 55 and older	18.90

D GROUP SUPPLEMENTAL LIFE INSURANCE

Age is determined as of previous July 1

Coverage	Age	MONTHLY RATE
$10,000 LIFE & AD&D	Under age 40	$ 1.50
	Age 40 - 49	3.00
	Age 50 - 59	6.50
	Age 60 - 64	11.50
	Age 65 - 69	17.50
	Age 70 - 74	30.00
	Age 75 and older	44.00
$20,000 LIFE & AD&D	Under age 40	$ 3.00
	Age 40 - 49	6.00
	Age 50 - 59	13.00
	Age 60 - 64	23.00
	Age 65 - 69	35.00
	Age 70 - 74	60.00
	Age 75 and older	80.00
$30,000 LIFE & AD&D	Under age 40	$ 4.50
	Age 40 - 49	9.00
	Age 50 - 59	19.50
	Age 60 - 64	34.50
	Age 65 - 69	52.50
	Age 70 - 74	90.00
	Age 75 and older	132.00
$40,000 LIFE & AD&D	Under age 40	$ 6.00
	Age 40 - 49	12.00
	Age 50 - 59	26.00
	Age 60 - 64	46.00
	Age 65 - 69	70.00
	Age 70 - 74	120.00
	Age 75 and older	176.00

E GROUP SHORT TERM DISABILITY INCOME INSURANCE

Benefits are reduced by other income. Waiting period must be satisfied regardless of cause. You may select any amount of weekly benefits in the table at below/right as long as your contracted annual school salary is at least as the great as the amount shown in the annual salary column.

ANNUAL SALARY	WEEKLY BENEFIT	8th DAY	29th DAY
$ 1,300	$ 20	$ 2.00	$ 1.40
2,600	40	4.00	2.80
3,900	60	6.00	4.20
5,200	80	8.00	5.60
6,500	100	10.00	7.00
8,000	120	12.00	8.40
9,500	140	14.00	9.80
11,000	160	16.00	11.20
12,500	180	18.00	12.60
14,000	200	20.00	14.00
15,500	220	22.00	15.40
17,000	240	24.00	16.80
18,500	260	26.00	18.20
20,000	280	28.00	19.60
21,500	300	30.00	21.00
23,000	320	32.00	22.40
24,500	340	34.00	23.80
26,000	360	36.00	25.20
$ 27,500	$ 380	$ 38.00	$ 26.60
29,000	400	40.00	28.00
30,500	420	42.00	29.40
32,000	440	44.00	30.80
33,500	460	46.00	32.20
35,000	480	48.00	33.60
36,500	500	50.00	35.00
38,000	520	52.00	36.40
39,500	540	54.00	37.80
41,000	560	56.00	39.20
42,500	580	58.00	40.60
44,000	600	60.00	42.00
45,500	620	62.00	43.40
47,000	640	64.00	44.80
48,500	660	66.00	46.20
50,000	680	68.00	47.60
51,500	700	70.00	49.00

F GROUP LONG TERM DISABILITY INCOME INSURANCE

IMPORTANT: If you are enrolled in an employer-sponsored long term disability plan, you should know that enrollment in this plan may be of limited value. If you have any questions or concerns, be sure to contact your MESSA field representative.

You may elect one $100 monthly benefit unit for each $2,000 of annual school salary up to $30,000. The monthly benefit elected can be less than the amount allowed based on your salary, but not more. You must also elect a Maximum Benefit Period. This plan has a 52 week waiting period.

OPTION 1 Provides benefits for up to 5 years if disabled prior to age 66; up to 4 years if disabled while age 66; up to 3 years if disabled while age 67; up to 2 years if disabled while age 68; and up to 1 year if disabled at age 69 or older.

OPTION 2 Provides benefits up to age 70 if disabled prior to age 69; and up to 1 year if disabled at or after age 69.

Determine the unit rate below at your attained age for the option selected. Multiply the rate times the number of $100-units you elect. Example: If you are age 35, earn $18,200 in annual school salary and elect the maximum benefit allowed of 9 units ($900 monthly benefit) and also elect Option 2, your contribution rate is $2.70 (9 units at 30¢ per unit).

Age is determined as of previous July 1.

Option	Age	Rate	
OPTION 1	Under age 40	$ .20	for each $100 unit
	Age 40 - 49	.50	for each $100 unit
	Age 50 and older	1.40	for each $100 unit
OPTION 2	Under age 40	$ .30	for each $100 unit
	Age 40 - 49	.80	for each $100 unit
	Age 50 and older	2.10	for each $100 unit

If you are currently enrolled in Group Hospital Confinement Indemnity Insurance and want to verify your rates, please check with your employer's business office.