WAYNE STATE UNIVERSITY

Voluntary Dental Program
Cash-In-Lieu of Medical Recipients
(Non-Represented, AAUP & GEOC)
2013 Enrollment Form

Office Use Only
Effective Date
(BGA-)

EMPLOYEE INFORMATION

Sex (M/F)	Last Name	First Name	M.I.	Date of Birth

Home Street Address	City/State/Zip	Home Phone ( )

Banner ID	Email Address

Check One: ☐Single ☐2-Person ☐Family

Last Name	First Name	Sex (M/F)	Date of Birth	Relation Code	Social Security Number	Office Use Only

* **Relation Code:** S=Employee M=Spouse C=Child H=Handicapped Dependant O=Other Eligible Person

Dependent Information: List only eligible dependents that you are enrolling. All information for dependents such as Social Security Number and date of birth must be provided. Dependent eligibility rules are the same as Wayne State's medical plan.

Please complete this form and return to the Total Compensation & Wellness Department at the following address:

Total Compensation & Wellness
5700 Cass Avenue
3638 Academic / Administration Building
Detroit, MI 48202
Fax: 313-577-0637

Information on the Dental Program can be accessed on the Human Resources website at www.wayne.edu/hr/tcw

Your Authorization:

*I authorize **bi-weekly** deductions for dental plan coverage based on the rates listed below:*

12 Month

Single	$15.67	per pay period
Two Person	$31.49	per pay period
Family	$57.25	per pay period

9 Month

Single	$20.89	per pay period
Two Person	$41.99	per pay period
Family	$76.33	per pay period

Employee Signature: ______________________________ **Date:** ______________________

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. I understand that the rates for these plans will be deducted from my paycheck and I will be responsible for any retro premiums and that any changes to your plan enrollment is subject to IRC Section 125 (http://wayne.edu/hr/tcw/health-welfare/section125-changes.pdf)