



Employee Benefit Enrollment/Change Form

Security Alert: Do not send this form via E-mail

Department Use Only:

Employee Name (Last, First) <i>Please print</i>	Banner ID	Social Security No.	Date of Birth
Street Address	City	State	Zip
Date of Hire	Work Phone	Home Phone	Email/Access ID

Please check one: New Hire Enrollment Open Enrollment Change Life Status Change (must supply Life Status Change form and proof of eligibility)

<p>Pre and Post Tax Medical Deductions Check Only One <input type="checkbox"/> I elect PRE-TAX deductions (Default) (3/A) <input type="checkbox"/> I elect POST-TAX deductions (4/B)</p>	Department Use Only								
<p>Medical Insurance Check Only One (See rate schedules for plan costs.)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Total Health Care HMO (BTA/BTB)</td> <td style="width: 50%; border: none;"><input type="checkbox"/> DMC Care PPO (BDA/BDB)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Health Alliance Plan HMO (BCA/BCB)</td> <td style="border: none;"><input type="checkbox"/> Community Blue PPO (BEA/BEB)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Blue Care Network HMO (BBA/BBB)</td> <td style="border: none;"><input type="checkbox"/> Blue Cross Blue Shield (BAA/BAB)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Waive Medical Coverage (BE9)</td> <td style="border: none;"><input type="checkbox"/> Cash In Lieu of Medical (BCML) MUST submit Cash In Lieu of Medical Form and proof of other group coverage to receive cash benefit.</td> </tr> </table> <p style="text-align: center;">For rate schedule and medical plan descriptions: http://hr.wayne.edu/tcw/health-welfare/med-insurance.php</p>	<input type="checkbox"/> Total Health Care HMO (BTA/BTB)	<input type="checkbox"/> DMC Care PPO (BDA/BDB)	<input type="checkbox"/> Health Alliance Plan HMO (BCA/BCB)	<input type="checkbox"/> Community Blue PPO (BEA/BEB)	<input type="checkbox"/> Blue Care Network HMO (BBA/BBB)	<input type="checkbox"/> Blue Cross Blue Shield (BAA/BAB)	<input type="checkbox"/> Waive Medical Coverage (BE9)	<input type="checkbox"/> Cash In Lieu of Medical (BCML) MUST submit Cash In Lieu of Medical Form and proof of other group coverage to receive cash benefit.	Eff Date: _____ DOH: _____ E Class: _____ Med: _____ Dental: _____ Vision: _____ Life: _____ LTD: _____ Sup Life: _____ Dep Life: _____
<input type="checkbox"/> Total Health Care HMO (BTA/BTB)	<input type="checkbox"/> DMC Care PPO (BDA/BDB)								
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<p>Vision Coverage: Check Only One <input type="checkbox"/> Basic (BVS) <input type="checkbox"/> Enhanced Buy-Up (BVE)</p> <p>Note that Basic vision insurance is bundled with medical insurance for all eligible groups. If you elect medical and are eligible, you will receive Basic vision coverage unless you elect Enhanced Buy-Up.</p> <p>Voluntary Vision Coverage: Non-Medical Plan Participants Only For those electing Cash In Lieu of Medical coverage, complete the Voluntary Vision Plan Enrollment Form to elect a voluntary vision plan. www.wayne.edu/hr/tcw/forms.php</p>									
<p>Dental Coverage Check Only One <input type="checkbox"/> Delta Dental (BGA) <input type="checkbox"/> Waive Dental Coverage (BG9)</p> <p>Voluntary Dental Coverage: Non-Medical Plan Participants Only For those electing Cash In Lieu of Medical coverage, complete the Voluntary Dental Plan Enrollment Form to elect a voluntary dental plan. www.wayne.edu/hr/tcw/forms.php</p>									
<p>Life/AD&D Insurance (BL5/A/3/4/D) The Basic and Supplemental Life/AD&D Enrollment/Change Form is found here: www.wayne.edu/hr/tcw/forms.php</p>									

Membership Information: Please provide requested information for self and each dependent you wish to enroll. If you are enrolling in a HMO plan (HAP, BCN, THC), you MUST select a Primary Care Physician and add to the table below for yourself and each dependent. The University reserves the right to request additional documentation to verify eligibility of all dependents. Valid social security numbers and required documentation must be submitted for all dependents being added to the plans.

Last Name	First Name	Social Security Number (Required)	Sex (M/F)	DOB (M/D/Y)	Relation Code*	Required Documentation (attach)	Primary Care Physician Name & ID # If HMO, must complete	Office Use
(Self)						N/A		
(Spouse/OEP)						1040/Other		
(Child)						Birth Certificate		
(Child)						Birth Certificate		
(Child)						Birth Certificate		

***Relation Code:** S=Employee, M=Spouse, C=Child, R=Senior Rider, O=Sponsored Dependent, H=Disabled Dependent, O=Other Eligible Person
 The information listed above is correct to the best of my knowledge. I authorize bi-weekly deductions, if appropriate, for insurance based on the current rates and any future rate increases. I certify that the names above are legal and eligible dependents. I understand that falsely certifying eligibility requirements in any respect could result in disciplinary action, that the University may request additional eligibility evidence, that I will be liable for all expenditures for coverage and benefits plus any administrative expenditure and that I must notify the Total Compensation and Wellness Department immediately when a dependent becomes ineligible. I authorize release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format. I have provided required documentation to support proof of dependency.

Employee Signature	Date
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Please return to: HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637