



Voluntary Dental Plan Enrollment Form 2017 Cash-In-Lieu of Medical Recipients (Non-Represented, AAUP & GEOC)

Office Use Only
Effective Date
(BGA-)

*Complete this form if you have cash in-lieu and are **not** enrolled in a WSU Medical Plan
Security Alert: DO NOT e-mail this form.*

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		Access ID	

Check One: Single 2-Person Family

Last Name	First Name	Sex (M/F)	DOB (M/D/Y)	Relation Code	Social Security Number	Check Box to Add or Terminate Dental		Office Use Only
						Add	Terminate	
(Self)								

* **Relation Code:** S=Employee M=Spouse C=Child H=Handicapped Dependent 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 HR Employee Resource Center

HR Employee Resource Center
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 <http://hr.wayne.edu/tcw/benefits/index.php>

Your Authorization:

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

<u>12 Month</u>			<u>9 Month</u>		
Single	\$15.53	per pay period	Single	\$20.71	per pay period
Two Person	\$30.85	per pay period	Two Person	\$41.13	per pay period
Family	\$56.08	per pay period	Family	\$74.77	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>). I understand I cannot cancel for a 12 month period based upon my enrollment date.