



Voluntary Vision Plan Enrollment Form 2017 Benefit Eligible Groups Only

*Complete this form ONLY if you do not enroll in a WSU medical plan.
Must be completed in full. Incomplete forms may delay benefit processing.*

<i>Departmental Use Only</i>
Effective Date: _____
Enrolled in Cash in Lieu of Medical: <input type="checkbox"/>
Not enrolled in WSU Medical Plan: <input type="checkbox"/>

Employee Name (Last, First) <i>Please print</i>	Banner ID	Access ID	Date of Birth
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Street Address	City	State	Zip
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Date of Hire	Work Phone	Home Phone	Email
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

Please check one: Add Change *Please check one:* Basic Plan Enhanced Buy-Up Plan

Dependent Information: Please provide requested information for self and each dependent you wish to cover. Only eligible dependents may be enrolled. All information for dependents such as Social Security Number and Date of Birth must be provided. The University reserves the right to request additional documentation to verify eligibility of all dependents. List only eligible dependents that you are enrolling. Dependent eligibility rules are the same as Wayne State University's medical plan.

Last Name	First Name	Social Security Number (Required)	Sex (M/F)	DOB (M/D/Y)	Relation Code*	Office Use Only
(Self)						

*Relation Code: S=Employee, M=Spouse, C=Child, R=Senior Rider, O=Sponsored Dependent, H=Disabled Dependent, O=Other Eligible Person

Your Authorization

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

Per-Pay Rate Comparison – Basic Plan vs. Enhanced Buy-Up Plan		
Coverage Level	Basic Plan– Bi-Weekly Costs <i>Total Premium</i>	Enhanced Buy-Up Plan– Bi-Weekly Costs <i>Total Premium</i>
Single		
12-Month	\$4.24	\$7.46
9-Month	\$5.64	\$9.95
Two Person		
12-Month	\$8.02	\$14.12
9-Month	\$10.68	\$18.82
Family		
12-Month	\$11.79	\$20.78
9-Month	\$15.72	\$27.70

*I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. **Once I elect EyeMed vision coverage, I understand that I cannot cancel for a 12-month period based upon my enrollment date.** I understand my vision contract will be renewed annually and the rates for this plan will be negotiated between my employer and EyeMed Vision Care. I understand my coverage will be renewed automatically each year. **I may only cancel during the open enrollment period by submitting the Employee Benefit Plan Termination Form.***

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