



# Employee Benefit Enrollment/Change Form

*Department Use Only:*

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

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 supporting documentation)

<p><b>Pre and Post Tax Medical Deductions:</b> 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> <p><b>Medical Insurance:</b> Check Only One (See rate schedules for plan costs.)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Total Health Care HMO (BTA/BTB)</td> <td><input type="checkbox"/> Community Blue PPO (BEA/BEB)</td> </tr> <tr> <td><input type="checkbox"/> Health Alliance Plan HMO (BCA/BCB)</td> <td><input type="checkbox"/> Blue Cross Blue Shield (BAA/BAB)</td> </tr> <tr> <td><input type="checkbox"/> Blue Care Network HMO (BBA/BBB)</td> <td><input type="checkbox"/> Cash In Lieu of Medical (BCM/L) MUST submit Cash In Lieu of Medical Form and proof of other group coverage to receive cash benefit.</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Waive Medical Coverage</td> </tr> </table> <p style="text-align: center;">For rate schedule and medical plan descriptions: <a href="http://hr.wayne.edu/tcw/health-welfare/med-insurance">http://hr.wayne.edu/tcw/health-welfare/med-insurance</a></p> <p><b>Vision Coverage:</b> 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><b>Voluntary Vision Coverage:</b> <i>Non-Medical Plan Participants Only</i>          For those electing Cash In Lieu of Medical coverage, complete the Voluntary Vision Plan Enrollment Form to elect a voluntary vision plan. <a href="http://www.wayne.edu/tcw/forms">www.wayne.edu/tcw/forms</a></p> <p><b>Dental Coverage:</b> Check Only One  <input type="checkbox"/> Delta Dental (BG3/BGA)  <input type="checkbox"/> Waive Dental Coverage (BG9)</p> <p><b>Life/AD&amp;D Insurance</b> (BL5/A/3/4/D) (for eligible employee groups)</p>	<input type="checkbox"/> Total Health Care HMO (BTA/BTB)	<input type="checkbox"/> Community Blue PPO (BEA/BEB)	<input type="checkbox"/> Health Alliance Plan HMO (BCA/BCB)	<input type="checkbox"/> Blue Cross Blue Shield (BAA/BAB)	<input type="checkbox"/> Blue Care Network HMO (BBA/BBB)	<input type="checkbox"/> Cash In Lieu of Medical (BCM/L) MUST submit Cash In Lieu of Medical Form and proof of other group coverage to receive cash benefit.	<input type="checkbox"/> Waive Medical Coverage		<p style="text-align: center;"><b>Department Use Only</b></p> <p>Eff Date: _____</p> <p>DOH: _____</p> <p>E Class: _____</p> <p>Med: _____</p> <p>Dental: _____</p> <p>Vision: _____</p> <p>Life: _____</p> <p>LTD: _____</p> <p>Sup Life: _____</p> <p>Dep Life: _____</p>
<input type="checkbox"/> Total Health Care HMO (BTA/BTB)	<input type="checkbox"/> Community Blue PPO (BEA/BEB)								
<input type="checkbox"/> Health Alliance Plan HMO (BCA/BCB)	<input type="checkbox"/> Blue Cross Blue Shield (BAA/BAB)								
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<input type="checkbox"/> Waive Medical Coverage									

**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 <b>(Required)</b>	Sex (M/F)	DOB (M/D/Y)	Relation Code*	Required Documentation (attach)	Primary Care Physician Name & ID # If HMO, must complete	Office Use
(Self)					S	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 HR Service Center 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; Email: askhr@wayne.edu