Voluntary Vision Plan
Enrollment Form 2019
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.

Departmental Use Only
Effective Date:
Enrolled in Cash in Lieu of Medical: ☐
Not enrolled in WSU Medical Plan: ☐

Employee Name (Last, First) *Please print* | Banner ID | Access ID | Date of Birth

Street Address | City | State | Zip

Date of Hire | Work Phone | Home Phone | Email

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 H=Handicapped Dependent O=Other Eligible Person

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

Per-Pay Rates – Basic Plan vs. Enhanced Buy-Up Plan

Coverage Level	Basic Plan *Total Bi-Weekly Cost*	Enhanced Buy-Up Plan *Total Bi-Weekly Cost*
Single		
12-Month	$4.23	$7.46
9-Month	$5.64	$9.95
Two Person		
12-Month	$8.01	$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

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