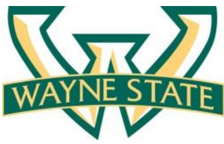

Employee Benefit Enrollment/Change Form

Security Alert: Do not send this form via email

Department Use Only:

Employee Name (Last, First) *Please print*	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)

Pre and Post Tax Medical Deductions Check Only One
☐ I elect PRE-TAX deductions (Default) (3/A) ☐ I elect POST-TAX deductions (4/B)

Medical Insurance Check Only One (See rate schedules for plan costs.)

- ☐ Total Health Care HMO (BT3/4)(BTA/BTB)
- ☐ Health Alliance Plan HMO (BC3/4) (BCA/BCB)
- ☐ Blue Care Network HMO (BB3/4) (BBA/BBB)
- ☐ Waive Medical Coverage
- ☐ DMC Care PPO (BD3/4) (BDA/BDB)
- ☐ Community Blue PPO (BE3/4) (BEA/BEB)
- ☐ Blue Cross Blue Shield (BA1/4) (BAA/BAB)
- ☐ 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.

For rate schedule and medical plan descriptions: http://hr.wayne.edu/tcw/health-welfare/med-insurance.php

Vision Coverage: Check Only One ☐ Basic (BVS) ☐ Enhanced Buy-Up (BVE)

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.

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

Dental Coverage Check Only One

- ☐ Delta Dental (BG3/BGA)
- ☐ Waive Dental Coverage (BG9)

Life/AD&D Insurance (BL5/A/3/4/D)
The Basic and Supplemental Life/AD&D Enrollment/Change Form is on the back of this form.

Department Use Only

Eff Date: ________
DOH: __________
E Class: ________
Med: ___________
Dental: _________
Vision: __________
Life: ____________
LTD: ___________
Sup Life: ________
Dep Life: ________

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

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