Employee Benefit Enrollment Form

Office Use Only:

Employee Name (Last, First) Please print	Banner ID	Social Security Number	Date of Birth
Date of Hire	**Work Phone**	**Home Phone**	**Email/Access ID**

Check one: ☐ New Hire ☐ Open Enrollment Change ☐ Life Status Change Event (attach Life Status/Open Enrollment Change Form)

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

Medical Insurance: Check Only One

☐ Total Health Care HMO (BTA/BTB)
☐ Health Alliance Plan HMO (BCA/BCB)
☐ Blue Care Network HMO (BBA/BBB)
☐ Waive Medical Coverage (BE9)
☐ Community Blue PPO (BEA/BEB)
☐ Blue Cross Blue Shield (BAA/BAB)
☐ Cash in Lieu of Medical (BCM/L) MUST submit Cash in Lieu of Medical Form to receive cash benefit.

For costs and descriptions: hr.wayne.edu/tcw/health-welfare/med-insurance

Vision Insurance: Check Only One ☐ Basic (BVS) ☐ Enhanced Buy-Up (BVE) ☐ Waive Vision (BV9)

Note: Basic vision insurance is bundled with medical insurance for all eligible groups. If you elect medical, you will be enrolled in Basic vision coverage unless you elect Enhanced Buy-Up.

Voluntary Vision Insurance: *Non-Medical Plan Participants Only* Check Only One ☐ Basic (BVV) ☐ Enhanced Buy-Up

For costs and descriptions: hr.wayne.edu/tcw/health-welfare/vision-plan

Dental Insurance Check Only One ☐ Delta Dental (BGA) ☐ Waive Dental Coverage (BG9)

Voluntary Dental Insurance: *Non-Medical Plan Participants Only* ☐ Delta Dental (BGV)

For costs and descriptions: hr.wayne.edu/tcw/health-welfare/dental-insurance

Life/AD&D Insurance Complete the Basic and Supplemental Life/AD&D Enrollment/Change Form to designate beneficiary(ies) – Basic Life is employer paid. For costs and descriptions: hr.wayne.edu/tcw/health-welfare/life-insurance

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Eff Date: _____
DOH: _____
E Class: _____
Med: _____
Dental: _____
Vision: _____
Life: _____
LTD: _____
Sup Life: _____
Dep Life: _____

Dependent Information: Complete table for self and each dependent you wish to enroll. If you are enrolling in an HMO (HAP, BCN, THC), you MUST select a Primary Care Physician for yourself and each dependent. Valid Social Security Numbers and required documentation must be submitted for all dependents added to the plans. The university reserves the right to request additional documentation to verify eligibility of dependents.

Last Name	First Name	Social Security Number (Required)	Sex (M/F)	DOB (M/D/Y)	Relation Code*	**Attach Required Documentation**	HMO must complete: Primary Care Physician Name & ID #	Office Use Only
(Self)					S	N/A		
						1040/Other		
						Birth Certificate		
						Birth Certificate		
						Birth Certificate		

***Relation Code:** S=Employee, M=Spouse, C=Child, O=Sponsored Dependent, H=Disabled Dependent, P=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 _____

Attach required documentation and return to:
HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637; E-mail: askhr@wayne.edu. Use your WSU E-mail and include "#SECURE" in the subject line to ensure your personal information is encrypted.