Cash in Lieu of Medical Form

For benefit-eligible classifications only

Office Use Only:

Employee Name (Last, First) Please print	Banner ID	Email/Access ID	Date of Birth

Work Phone	Home Phone

Please check each box if you would like to:

- ☐ Enroll in Life Insurance (attach Basic and Supplemental Life/AD&D Enrollment/Change form)
- ☐ Enroll in Dental (attach Employee Benefit Enrollment Form)
- ☐ Enroll in Voluntary Vision (attach Employee Benefit Enrollment Form)

Please read each of the following statements and check each box:

☐ I certify that I am covered by another medical plan and have attached verification of my coverage offered through:

Insured's Name: ______________________

Insured's Employer: ______________________

Medical Plan: ______________________

(Plan listed is not a WSU medical plan)

☐ I understand that, by exercising the election to receive biweekly payments, I will receive no benefits or coverage from any Wayne State University group medical plan. If I wish to enroll in any of Wayne State University's group medical plans at a later date, I will be subject to that plan's enrollment rules. If I am added as a dependent to a WSU plan at a later date, I will notify WSU to terminate the Cash in Lieu of Medical benefit.

☐ I understand that under no circumstances will the Cash in Lieu of Medical benefit be made retroactive.

☐ I understand that if I am a 9-month employee and elect to enroll in any Wayne State University group medical plan mid-year (due to a qualifying change), I will owe the university for pre-payment of the Cash in Lieu of Medical benefit made to me for the summer months.

☐ I understand that my eligibility for the Cash in Lieu of Medical benefit is subject to an annual recertification process.

☐ I understand by electing Cash in Lieu of Medical, I may not be eligible for subsidized dental or bundled vision. I have the option to elect voluntary coverage.

☐ I certify that I am covered by another non-WSU medical plan. I certify that I will maintain coverage in this medical insurance plan on an ongoing basis and I agree to notify the HR Service Center within 30 days if I lose coverage under the medical insurance plan listed above.

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.