Voluntary Dental & Vision Plan Program
2018 -2019 Enrollment/Change Form
Eligible Part-Time Faculty (AFT Local 477, AFL-CIO)
Deadline Date – September 7, 2018

WAYNE STATE UNIVERSITY

Office Use Only
Effective Date
(BGP-)

(BVP-)

EMPLOYEE INFORMATION

Banner ID	Last Name	First Name	M.I.	Date of Birth

Home Street Address	City/State/Zip	Home/Cell Phone ( )

Social Security Number	Email Address

Last Name	First Name	Sex (M/F)	Date of Birth	Relation Code *	SSN and supporting proof of dependent status (Required)	Check Box to (A) Add Dental	Vision	Office Use Only
				Self				

* **Relation Code:** S=Employee M=Spouse C=Child H=Handicapped Dependant

Dependent Information: List only eligible dependents that you are enrolling. All information for dependents such as Social Security Number and date of birth must be provided. Dependent eligibility rules are the same as Wayne State's medical plan. *See dependent supporting documentation requirements: https://hr.wayne.edu/tcw/health-welfare/dependent-supporting-documentation.pdf. Supporting dependent documentation must be submitted with enrollment form.*

(A) Add: New (individual) enrollment during the contract period or within 30 days of a qualifying life status change (birth, marriage, etc.).

ID Cards: ID cards are not issued by Delta Dental. Your vision ID card will be mailed by EyeMed. For more information on the program, please visit our website at http://www.hr.wayne.edu/tcw.

Please complete this form and return to the HR Service Center at the following address:

Human Resources Service Center
5700 Cass Avenue, 3638 Academic / Administration Building
Detroit, MI 48202
Fax: 313-577-0637

Your Authorization:

*I authorize **bi-weekly** deductions for dental and/or vision plan coverage based on the Part-Time Faculty rates (14 bi-weekly deductions, beginning the pay of 9/19/2018) listed below:*

Coverage Level	Dental Plan *Bi-weekly Employee Deduction*	Basic Vision Plan *Bi-weekly Employee Deduction*	Enhanced Vision Plan *Bi-weekly Employee Deduction*
Single	$26.78	$7.25	$12.79
2-Person	$51.27	$13.73	$24.20
Family	$90.03	$20.21	$35.61

Employee Signature: _____ **Date:** _____

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. **I understand I cannot cancel for a 12 month period based upon my enrollment date without a qualifying Section 125 life event.** I understand that the rates for these plans will be deducted from my paycheck and I will be responsible for any retro premiums. This form will not be accepted after the specified deadline of September 7, 2018.

Departmental Sign-Off

(Please complete required departmental signature before submitting form)

Name: _____ **Signature:** _____ **Date:** _____

Title (Associate Dean/Department Chair/Assistant Dean-College of Education): _____

This is to certify that the above-named part-time faculty member is expected to teach at least one full semester course in the forthcoming fall semester and one course in the forthcoming winter semester.