For the Benefits & Wellness Department use only
Effective Date

Retiree & LTD Recipient Dental Plan Enrollment Form

RETIREE/LTD RECIPIENT INFORMATION

☐ Add ☐ Term ☐ Change	☐ M ☐ F	Last Name (Retiree/LTD Recipient)	First Name	M.I.	Date of Birth

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

Social Security Number	E-mail Address (If Applicable)

☐ A ☐ T	☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number	Relationship
☐ A ☐ T	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Relationship
☐ A ☐ T	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Relationship

Instructions:

Please complete this form and return to the Benefits & Wellness Department at the following address:

Benefits & Wellness
5700 Cass Avenue
3638 Academic / Administration Building
Detroit, MI 48202

Family Information: List only eligible family members who are enrolling. All information for family members such as Social Security Number and date of birth must be provided. Dependent eligibility is the same as Wayne State's medical plan.

(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, address or phone.

Information on the Retiree Dental Program can be accessed on the Human Resources website at www.hr.wayne.edu/tcw

2017 Dental Plan Rates

Single	$37.80 per month
Two-person	$73.12 per month
Family	$121.61 per month

Signature: ______________________ **Date:** ______________

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. Once I elect Delta Dental coverage, I understand I cannot cancel for a 12 month period based upon my enrollment date. I understand that my dental contract will be renewed annually and the rates for this plan will be negotiated between Wayne State University and Delta Dental. I understand that my coverage will be renewed automatically each year. I understand that if I or my dependents drop this coverage, I will have to wait until the first open enrollment following 12 months to re-enroll.

Please return to: Benefits & Wellness, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637

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