Retirees, Surviving Spouse & LTD Recipients Vision Plan Enrollment Form

Department Use Only:	67
Effective Date:	

Retiree/LTD Recipient Name (Last, First) *Please print* | Social Security Number | Access ID | Date of Birth

Street Address | City | State | Zip

Home Phone | Email

Please check one: ☐ Add ☐ Terminate ☐ Change of Name, Address or Phone

Please check one: ☐ Basic Plan ☐ Enhanced Buy-Up Plan

Dependent Information: Please provide requested information for self and each dependent you wish to cover. Only eligible dependents may be enrolled. All information for dependents such as Social Security Number and Date of Birth must be provided. The University reserves the right to request additional documentation to verify eligibility of all dependents. List only eligible dependents that you are enrolling. Dependent eligibility rules are the same as Wayne State University's medical plan.

Last Name	First Name	Social Security Number (Required)	Sex (M/F)	DOB (M/D/Y)	Relationship	Check Box to Add or Terminate Vision		Office Use Only
						Add	Terminate	

Basic Plan vs. Enhanced Buy-Up Plan Premium Schedule

Coverage Level	Basic Plan– Monthly Costs *Total Premium*	Enhanced Buy-Up Plan– Monthly Costs *Total Premium*
Single		
12-Month	$8.46	$14.92
Two Person		
12-Month	$16.02	$28.23
Family		
12-Month	$23.58	$41.55

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. **Once I elect EyeMed vision coverage, I understand that I cannot cancel for a 12-month period based upon my enrollment date.** I understand my vision contract will be renewed annually and the rates for this plan will be negotiated between my employer and EyeMed Vision Care. I understand my coverage will be renewed automatically each year. I may only cancel during the open enrollment period.

Employee Signature | Date

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