Benefit Intent Form
Retirees, Surviving Spouses & LTD Recipients

Name (Last, First) *Please print*	Banner ID	Social Security Number	Date of Birth

Street Address	City	State	Zip

Phone	E-mail

The purpose of this form is to inform the HR Service Center of your intentions to select benefits at the time of retirement, long-term disability eligibility or surviving spouse eligibility. This is NOT an enrollment form and you **will not** be enrolled in a medical, dental and/or vision plan until the appropriate enrollment forms are submitted. **Retirees:** this form should be submitted, along with enrollment form(s), at least 2 weeks prior to your date of retirement. **Surviving Spouses and Long-term Disability Recipients:** this form should be submitted, along with enrollment form(s), within 30 days of your eligibility date.

Please check all that apply:

☐ I intend to elect **retiree medical insurance** and have enclosed my enrollment form. Community Blue (PPO) and Total Health Care (HMO) are not retiree medical insurance plan options. If you were previously enrolled in either of these active employee plans, and you wish to enroll in retiree medical insurance through the university, you will need to choose a new plan. If you are a retiree or surviving spouse and enrolling in Aetna, your Aetna enrollment form must be sent directly to Aetna.

☐ I intend to elect **retiree dental insurance*** and have enclosed my enrollment form.

☐ I intend to elect **retiree vision insurance*** and have enclosed my enrollment form.

☐ I intend to elect COBRA continuation of my medical, dental and/or vision benefits. I understand this intent form is NOT a COBRA enrollment form and I will be contacted directly by the university's third party COBRA administrator to make my COBRA election.

I understand the university's billing agent will send me a coupon booklet with which I make monthly payments. I understand and agree that I must make the full monthly payment by the first of the month for the given month's coverage. I understand and agree that if I fail to make timely payments, the university will cancel my coverage retroactive to the last day of the month for which a payment was received and will proceed with any legal methods available to collect money due the university. I understand and agree that if I wish to cancel coverage, I must provide written notice to the HR Service Center via a termination letter or the Medical Plan Termination Form for Retirees, Surviving Spouses and LTD Recipients.

I agree to notify the HR Service Center of any change of address.

*Retiree dental and retiree vision are not available to surviving spouses.

Signature	Date

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.