Medical Plan Election Form

Retirees, Surviving Spouses & LTD Recipients

To Enroll, Change or Terminate Coverage

This form must be submitted within 30 days of your eligibility date, the date of status change event (marriage, birth, etc.) or by the annual Open Enrollment period deadline in order for enrollment requests to be processed. Please see the Retiree Benefits Handbook (pages 14-15) for eligibility guidelines. All dependent information must be provided in order for enrollment requests to be processed. See dependent supporting documentation requirements: https://hr.wayne.edu/tcw/benefits/dependents. **If age 65+, attach a copy of Medicare card for yourself and/or dependents.**

Retiree/Surviving Spouse/LTD Recipient Information

Name (Last, First) *Please print*

Banner ID

Social Security Number

Date of Birth

Street Address

City

State & ZIP

County

Event (Retiring, LTD, COBRA ending, Open Enrollment, etc.)

Phone

☐ If age 65+ I've attached a copy of Medicare card (check box)

Select One:

☐ Enroll in Coverage ☐ Change Plan ☐ Add Dependent
☐ Remove Dependent ☐ Terminate Coverage

Select One:

☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network (HMO) ☐ Health Alliance Plan (HMO)

Check Box to Enroll or Terminate Coverage		Event Date*	Last Name	First Name	Relation Code**	Social Security Number	Date of Birth	Sex (M/F)	Physician or Center Code (Required for HMO)
Enroll/ Add	Terminate/ Remove								
☐	☐		(self)		S				
☐	☐								
☐	☐								
☐	☐								

Please list other medical coverage, such as Medicare (including dependent's Medicare). Include name, group number, Medicare effective dates and policy number, dependents covered:

***Date of status change event**: COBRA Ending, LTD Begin, Marriage, Birth/Adoption, Court Orders, etc.
****Relation Code:** S=Employee, M=Spouse, C=Child, O=Sponsored Dependent, H=Disabled Dependent, P=Other Eligible Person

The information listed above is correct to the best of my knowledge. I understand I am responsible for payment of the medical insurance premiums based on the current rates and any future rate increases. I understand that the university may ask me to provide evidence that the eligibility requirements are being met. I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature

Date

Attach required documentation and submit 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.