Medical Plan Enrollment Form

Retirees, Surviving Spouses & LTD Recipients

To Enroll, Change Coverage or Add a Dependent

This form must be received by the HR Service Center 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 to take effect.

Retiree/Surviving Spouse/LTD Recipient Information

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

Street Address	City	State & Zip Code	County

Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date

Select One Plan Only:

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

Dependents to be Covered: All information for dependents such as Social Security Number, Date of Birth, and dependent supporting documentation must be provided, otherwise they will not be enrolled. See dependent supporting documentation requirements: hr.wayne.edu/tcw/health-welfare/dependent-supporting-documentation.pdf.

Check "add" box if adding dependent. You must provide a Primary Care Physician code if enrolling in an HMO.

Add	Event Date*	Last Name	First Name	Relation Code**	Social Security Number	Date of Birth	Sex (M/F)	Physician or Center Code (HMO Only)
		(self)		S				

Please list other medical coverage including Medicare (include name, group number, Medicare effective dates and policy number, dependents covered):

*__Date of status change event__: Marriage, Other Eligible Person Relationship, 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 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.

hr.wayne.edu/tcw