Vision Plan Election Form

Retirees & LTD Recipients

To Enroll, Change or Terminate Coverage

Retiree/LTD Recipient Information

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

Street Address	City	State	Zip

Phone	E-mail	Event (Retiring, LTD, COBRA ending, Open Enrollment, etc.)

Please check one to enroll in: WSU Retiree EyeMed Vision Group #1035652

☐ Basic Plan ☐ Enhanced Buy-Up Plan

Dependent Information: List eligible dependents that you are enrolling or terminating. All information for dependents such as Social Security Number, date of birth, and dependent supporting documentation must be provided (LTD recipients only), otherwise they will not be enrolled. See dependent supporting documentation requirements: https://hr.wayne.edu/tcw/benefits/dependents

Check Box to Add or Terminate Vision		Last Name	First Name	Social Security Number	Sex (M/F)	Date of Birth	Relation Code*
Add	Terminate						
☐	☐	(Self)					S
☐	☐						
☐	☐						
☐	☐						

***Relation Code:** S=Employee, M=Spouse, C=Child, O=Sponsored Dependent, H=Disabled Dependent, P=Other Eligible Person

Retiree vision plan rates are listed here: https://hr.wayne.edu/tcw/health-welfare/medical-rates

Acknowledgment of Enrollment Guidelines:

I hereby certify that the information listed above is correct to the best of my knowledge. I understand that the university may ask me to provide evidence that the dependent eligibility requirements are being met. I understand I am responsible for payment of the vision insurance premiums based on the current rates and any future rate increases. I understand my vision contract will be renewed automatically annually and the rates for this plan will be negotiated between WSU and EyeMed.

I understand that I cannot cancel for a 12-month period based upon my enrollment date. I understand payments are due by the first of the month for the given month's coverage. Payments not received within 45 days will result in cancellation of coverage. If I do cancel for any reason during the 12-month period I may not re-enroll until the first Open Enrollment period following 12 months from my coverage end date. In order to re-enroll I must first remit all back premiums for the 12-month period in which I canceled previously. 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.

☐ I agree (check box)

Signature	Date

Attach required documentation (if applicable) 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.