



Employee Benefit Enrollment/Change Form

Employee must complete in full (print or type). Incomplete forms may delay benefit processing. Return form to Total Compensation & Wellness.
NOTE: We **cannot** accept faxed Life Insurance forms.

5700 Cass Avenue, 3638 Academic/Administration Building, Detroit, MI 48202
Phone: (313) 577-3717

Department Use Only		Effective Date: _____
MED: _____	VISION: _____	E-Class: _____ DOH: _____
DENTAL: _____		NOTES: _____ INITIALS: _____
LIFE: _____	LTD: _____	
LIFE SUPP: _____		
LIFE DEP: _____		

Please check ONE: New Enrollment Open Enrollment Change Life Status Change (must supply form and proof of eligibility)

Name (Last, First, M.I.)	Banner ID# (Required)	Social Security Number	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Address	City	State*	ZIP/Postal Code
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MI <input type="checkbox"/> ON	<input type="text"/>

Date of Hire	WSU Department	Home Phone Number	Work Phone Number	E-mail
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

* Employees must give a valid local Michigan or Ontario address.

Medical Insurance Check Only One (See rate schedules for plan costs.) <input type="checkbox"/> Blue Cross Blue Shield (BA1/4) (BAA/BAB) <input type="checkbox"/> Community Blue PPO (BE3/4) (BEA/BEB) <input type="checkbox"/> DMC Care PPO (BD3/4) (BDA/BDB) <input type="checkbox"/> Health Alliance Plan HMO (BC3/4) (BCA/BCB) <input type="checkbox"/> Blue Care Network HMO (BB3/4) (BBA/BBB) <input type="checkbox"/> Total Health Care HMO (BT3/4) (BTA/BTB) <input type="checkbox"/> I have other group medical coverage MUST submit Cash In Lieu Form and proof of other group coverage to receive cash benefit. (BCM/L) <input type="checkbox"/> I elect NO COVERAGE (BE9)		Life/AD&D Insurance (BL5/A/3/4/D) (See pg.38) Please make all Hartford Basic and Supplemental life insurance elections on the Hartford Life Insurance Enrollment/Change form. Please note that we cannot accept faxed life insurance forms. If you are a current (not new) employee and wish to increase your supplemental insurance, you will also need to fill out a Personal Health Application. Vision Coverage (SA employees are not eligible for vision.) Note that vision insurance is bundled with medical insurance for all eligible groups. If you elect medical and are eligible, you will receive vision (BVS) Voluntary Vision Coverage: Non-Medical Participants For those electing Cash In Lieu of Medical Insurance ONLY , please fill out the Voluntary Vision form to elect Vision (Pg. 43).		Other Medical Insurance Please provide group name, number, and policy information for other insurance on your dependents.
Dental Coverage Check Only One <input type="checkbox"/> Enroll (BG3) <input type="checkbox"/> Do Not Enroll (BG9)	Graduate Assistant Dental <input type="checkbox"/> Base Plan-7441 (BG2) <input type="checkbox"/> Buy-Up Plan-7614 (BGU) <input type="checkbox"/> Do Not Enroll (BG9)	Pre- and Post-Tax Medical Deductions (See pg.7) Check Only One <input type="checkbox"/> I elect PRE-TAX deductions (default) (3) <input type="checkbox"/> I elect POST-TAX deductions (4)		

Department Use Only

Membership Information: Please provide requested information for self and each dependent you wish to cover. Check the box(es) to indicate if a dependent is to be covered under each benefit plan. **If you are enrolling in a HMO plan (HAP, BCN or THC), you MUST select a Primary Care Physician for each person.** The University reserves the right to verify eligibility of all dependents.

Last Name	First Name	Social Security Number	Sex (M/F)	DOB (M/D/Y)	Relation Code*	Check box to enroll each person		Required Documentation Attached (pg.36)	Primary Care Physician Name & ID #
						Med	Vision	Dental	
Self									

*Relation Code: S=Employee M=Spouse C=Child R=Senior Rider O=Sponsored Dependent H=Handicapped Dependent, O=Other Eligible Person

The information listed above is correct to the best of my knowledge. I authorize bi-weekly deductions, if appropriate, for insurance based on the current rates and any future rate increases.

I certify that the names above are legal and eligible dependents. I understand that falsely certifying eligibility requirements in any respect could result in disciplinary action, that the University may request additional eligibility evidence, that I will be liable for all expenditures for coverage and benefits plus any administrative expenditure and that I must notify the Total Compensation and Wellness Department immediately when a dependent becomes ineligible.

I authorize 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 have provided required documentation to support proof of dependency. (Page 36)

Employee Signature	Date Signed
<input type="text"/>	<input type="text"/>