



Retiree & LTD Recipient Vision Plan Enrollment Form

Wayne State University Retirees

Official Use
Effective
Date

RETIREE/LTD RECIPIENT INFORMATION

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Change	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Retiree)	First Name	M.I.	Date of Birth
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Home Street Address	City/State/Zip	Home Phone ()
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Social Security Number	E-mail Address (If Applicable)
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<input type="checkbox"/> A <input type="checkbox"/> T	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number	Relationship
<input type="checkbox"/> A <input type="checkbox"/> T	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Relationship
<input type="checkbox"/> A <input type="checkbox"/> T	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Relationship
<input type="checkbox"/> A <input type="checkbox"/> T	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Relationship

Instructions:

Please complete this form and return to the Total Compensation & Wellness Department at the following address:

**5700 Cass Avenue
3638 Academic / Administration Building
Detroit, MI 48202**

Vision Plan Rates:

Single	\$ 8.00	per month
Two Person	\$ 15.14	per month
Family	\$22.28	per month

Family Information: List only eligible family members who are enrolling. All information for family members such as Social Security Number and date of birth must be provided. Dependent eligibility is the same as Wayne State's medical plan.

(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.

(T) Terminate: To terminate enrollment.

(C) Change: A change of name, address or phone.

Signature: _____

Date: _____

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. Once I elect EyeMed vision coverage, I understand I cannot cancel for a 12 month period based upon my enrollment date. I understand that my vision contract will be renewed annually and the rates for this plan will be negotiated between Wayne State University and EyeMed Vision Care. I understand that my coverage will be renewed automatically each year. I may only cancel my coverage during the open enrollment period.