

**Retiree & LTD Recipient Dental Plan  
Enrollment Form**

**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/LTD Recipient)	First Name	M.I.	Date of Birth
Home Street Address			City/State/Zip		Home Phone ( )
Social Security Number		E-mail Address (If Applicable)			

<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

***Instructions:***

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

**Total Compensation & Wellness  
5700 Cass Avenue  
3638 Academic / Administration Building  
Detroit, MI 48202**

**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.

Information on the Retiree Dental Program can be accessed on the Human Resources website at [www.hr.wayne.edu/tcw](http://www.hr.wayne.edu/tcw)

***Dental Plan Rates:***

Single	\$25.11 per month
Two-person	\$46.49 per month
Family	\$80.01 per month

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. Once I elect Delta Dental coverage, I understand I cannot cancel for a 12 month period based upon my enrollment date. I understand that my dental contract will be renewed annually and the rates for this plan will be negotiated between Wayne State University and Delta Dental. I understand that my coverage will be renewed automatically each year. I understand that if I or my dependents drop this coverage, I will have to wait until the first open enrollment following 12 months to re-enroll.*