



Voluntary Vision Plan Enrollment/Change Form Non-Represented, AAUP, AFSCME, GEOC and P&A employees only

Official Use
Effective Date

EMPLOYEE INFORMATION

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Change	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Banner ID	Last Name (Employee)	First Name	M.I.	Date of Birth
Social Security Number			Home Street Address			City/State/Zip		Home Phone ()
Title				Department	Campus Address			Email Address

FAMILY INFORMATION (Only eligible dependents may be enrolled.)

	Sex	Last Name (<i>spouse</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F						
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name (<i>dependent</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name (<i>dependent</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name (<i>dependent</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name (<i>dependent</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name (<i>dependent</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use
<input type="checkbox"/> A <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name (<i>dependent</i>)	First Name	M.I.	Date of Birth	Social Security Number	Official Use

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

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, employee address or employee phone.

Information on the Vision Program can be accessed on the Human Resources website at www.hr.wayne.edu/tcw

Your Authorization:

I authorize **bi-weekly** deductions for vision plan coverage based on the rates listed below:

Single	\$ 4.00	per pay period
Two Person	\$ 7.57	per pay period
Family	\$11.14	per pay period

Employee 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 that 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 my employer and EyeMed Vision Care. I understand that my coverage will be renewed automatically each year. I may only cancel during the open enrollment period.