



Voluntary Vision Plan Enrollment Form

Benefit Eligible Groups Only

Official Use Only

Effective Date: _____

Enrolled in Cash In-Lieu of Medical

Not enrolled in WSU Medical Plan

PLEASE COMPLETE THIS FORM ONLY IF YOU DO NOT ENROLL IN A WSU MEDICAL PLAN.

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

Instructions:

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

**5700 Cass Avenue
3638 Academic/Administrative 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.

Information on the Vision Program can be accessed on the Human Resources website at <http://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 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 by submitting the Benefit Plan Termination Form.