

**Voluntary Dental & Vision Plan-Pilot Program
2011-2012 Enrollment Form
Eligible Part-Time Faculty (AFT Local 477, AFL-CIO)**

Office Use Only
Effective Date (BGP-)
(BVP-)

EMPLOYEE INFORMATION					
<input type="checkbox"/> Add <input type="checkbox"/> Term	Sex (M/F)	Last Name	First Name	M.I.	Date of Birth
Home Street Address		City/State/Zip		Home Phone ()	
Social Security Number			Email Address		

Last Name	First Name	Sex (M/F)	Date of Birth	Relation Code	Social Security Number	Check Box to (A) Add/ (T) Terminate		Office Use Only
						Dental	Vision	

* **Relation Code:** S=Employee M=Spouse C=Child H=Handicapped Dependant O=Other Eligible Person

Dependent Information: List only eligible dependents that you are enrolling. All information for dependents such as Social Security Number and date of birth must be provided. Dependent eligibility rules are the same as Wayne State's medical plan.

(A) Add: New (individual) enrollment during the contract period or open enrollment change.
(T) Terminate: To terminate enrollment due to loss in eligibility or after 12 months of coverage (open enrollment).

ID Cards: ID cards are not issued by Delta Dental. Your vision ID card will be mailed by Eyemed. For more information on the program, please visit our website at <http://www.hr.wayne.edu/tcw>

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**

Your Authorization:

*I authorize **bi-weekly** deductions for dental and/or vision plan coverage based on the 9 month rates (14 bi-weekly deductions) listed below:*

<u>EyeMed Vision</u>			<u>Delta Dental</u>		
Single	\$6.47	per pay period	Single	\$29.38	per pay period
Two Person	\$12.26	per pay period	Two Person	\$51.85	per pay period
Family	\$18.02	per pay period	Family	\$84.72	per pay period

Employee Signature: _____ **Date:** _____

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. I understand I cannot cancel for a 12 month period based upon my enrollment date. I understand that the rates for these plans will be deducted from my paycheck and I will be responsible for any retro premiums. I understand that if I/my dependents drop this coverage, I will have to wait until the first open enrollment following 12 months to re-enroll.

Departmental Sign-Off

Name: _____ **Signature:** _____ **Date:** _____

Title (Associate Dean/Department Chair/Assistant Dean-College of Education): _____
This is to certify that the above-named part-time faculty member is expected to teach at least one full semester course in the forthcoming fall semester and one course in the forthcoming winter semester.