WAYNE STATE UNIVERSITY

For the Total Compensation and Wellness Department use only Effective Date:

Medical Plan Enrollment Form For Retiree / Surviving Spouse / Eligible LTD Recipients

To Enroll, Change Coverage or Add a Dependent

Please print all information.

Your application must be received in the Total Compensation and Wellness Department within 30 days of the date of event (date of marriage, etc.) or by the communicated deadline for Open Enrollment in order for enrollment to take effect.

If you are adding dependents, proof may be required for your application to be considered complete and enrollment to take effect.

Retiree / Surviving Spouse / Eligible LTD Recipient Information

Social Security Number	Customer ID	Last Name	First Name	Middle I

Birth Date	Sex	Date of Retirement	Daytime Phone

Address and Street	City and State	Zip Code	County

Medicare Number	Hospital Insurance (Part A) Effective Date	Medical Insurance (Part B) Effective Date

Select One Plan Only

Please check the box next to the plan in which you wish to enroll.

Traditional Medical

☐ Blue Cross Blue Shield of Michigan

Health Maintenance Organization*

☐ Blue Care Network

☐ Health Alliance Plan

Preferred Provider Organization

☐ DMC Care

*You must select a primary care physician and complete the physician selection information in the column below.

Persons to be covered or added

Add	Event Date for Additions*	Relationship**	Social Security Number	Last Name	First Name	Birth Date (M-D-Y)	Sex	Physician or Center Code (do not complete for BCBS or DMC) If dual choice, list both codes.
		Self						

Other medical coverage including Medicare (include name, group number, Medicare effective dates and policy number) - Spouse, Other Eligible Person, Dependents, Children, etc.

*Date of New Marriage, Other Eligible Person Relationship, Court Orders, etc.

**Spouse, Other Eligible Person, Child, Disabled Child, Sponsored Dependent, Senior Rider.

The information listed above is correct to the best of my knowledge. I understand I am responsible for payment of the medical insurance premiums based on the current rates and any future rate increases. I understand that the University may ask me to provide evidence that the eligibility requirements are being met.

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature	Date Signed