

# WCAA HEALTH BENEFITS ENROLLMENT/CHANGE FORM – NON ACTIVES



|   |           |  |  |  |  |   |
|---|-----------|--|--|--|--|---|
| Social Security Number  | Last Name | First Name   | M.I.   | Date of Birth<br>Mo Day Yr<br>/ /  | Sex<br><input type="checkbox"/> Female<br><input type="checkbox"/> Male  | Please Submit Form To:<br>Wayne County<br>Airport Authority<br>1 L.C. Smith Building<br>Mezzanine<br>Detroit, Michigan 48242<br>FAX TO 734-955-5737 |
| Street Address  | City      | State  | Zip Code   | Telephone Numbers:<br>Daytime ( )<br>Evening ( )   |  |   |
| Marital Status: <input type="checkbox"/> Single<br><input type="checkbox"/> Married<br>Does your spouse work for WCAA? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Do you or dependents have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |           | Internal Use Only<br>Old Coverage<br>Carrier: _____<br>Group: _____<br>Eff. Date: _____<br>Completed by: _____ | Internal Use Only<br>New Coverage<br>Carrier: _____<br>Group: _____<br>Eff. Date: _____<br>Completed by: _____ | Internal Use Only<br>Old Coverage<br>Carrier: _____<br>Group: _____<br>Eff. Date: _____<br>Completed by: _____ | Internal Use Only<br>New Coverage<br>Carrier: _____<br>Group: _____<br>Eff. Date: _____<br>Completed by: _____ |   |

## Coverage Selection

| Medical Plan  | Dental Plan  |
|---|--|
| <b>Your Current Plan:</b><br><input type="checkbox"/> Blue Cross Blue Shield PPO <input type="checkbox"/> Opt-Out (Requires Proof of Insurance) <input type="checkbox"/> HAP<br><b>New Plan Selection:</b><br><input type="checkbox"/> Blue Cross Blue Shield PPO <input type="checkbox"/> Opt-out (Requires Proof of Insurance) <input type="checkbox"/> HAP | <b>Your Current Plan:</b><br><input type="checkbox"/> BCBS Dental <input type="checkbox"/> Golden Dental <input type="checkbox"/> Waived Dental Coverage<br><b>New Plan Selection:</b><br><input type="checkbox"/> BCBS Dental <input type="checkbox"/> Golden Dental <input type="checkbox"/> Waive Dental Coverage |

Relation Codes?: S-Spouse N-Natural /Adopted Child\* P-Principle Support\* SD-Sponsored Dependent\* F-Family Continuation (Dependent over age 19)\* SC-Stepchild\* A-Child Adoption in Process\*

C-Court Ordered Coverage\*\*LF-Legal Full Guardianship\*\* D-Disabled Child\*\*\* LL-Limited Legal Guardianship\*\* (\*Attach Documentation \*\*Attach Court Order \*\*\*Attach Letter From Social Security)

## Dependent Information (List all current and any new dependents)

|         | Action Codes <sup>1</sup> |        | Last Name | First Name | M.I. | Social Security Number | Sex | Relation Code <sup>2</sup> | Date of Birth<br>Mo Day Yr<br>/ / | Primary Physician<br>(HAP only)<br>Name/Site/Code |
|---------|---------------------------|--------|-----------|------------|------|------------------------|-----|----------------------------|-----------------------------------|---|
|         | A=Add R=Remove            |        |           |            |      |                        |     |                            |                                   |   |
|         | Medical                   | Dental |           |            |      |                        |     |                            |                                   |   |
| Spouse  |                           |        |           |            |      |                        |     | S                          | / /                               |   |
| Dep - 1 |                           |        |           |            |      |                        |     |                            | / /                               |   |
| Dep - 2 |                           |        |           |            |      |                        |     |                            | / /                               |   |
| Dep - 3 |                           |        |           |            |      |                        |     |                            | / /                               |   |
| Dep - 4 |                           |        |           |            |      |                        |     |                            | / /                               |   |

Do you, your spouse or dependent(s) maintain other health coverage?  Yes  No If yes, complete below

|  |         |                     |                 |          |
|--|---------|---------------------|-----------------|----------|
| All Members Covered <input type="checkbox"/> Yes <input type="checkbox"/> No | Carrier | Group/Policy Number | Carrier Address | Employer |
| Person Covered (Full Name)   | Carrier | Group/Policy Number | Carrier Address | Employer |

I acknowledge that the information that I have provided on this form is true to the best of my knowledge.

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