

HEALTH CARE INSURANCE 2011 OPEN ENROLLMENT PLAN CHANGE FORM

— Please Print —

NAME:	EMPLOYEE ID:
--------------	---------------------

IMPORTANT NOTICE: All changes requested herein are subject to the specific terms and conditions described in the appropriate collective bargaining agreement (CBA) or benefit plan. Not all plans listed below may be available to all employees based on the terms of their specific CBA or benefit plan. It is up to the employee to know which plans are available at the time in which they are completing this form. Any change requested that is inconsistent with the employee's labor agreement will be disregarded.

I would like to make the following changes to my medical and/or dental insurance:

	CURRENT INSURANCE PLAN	EFFECTIVE NOVEMBER 1 st CHANGE PLAN TO
MEDICAL Select ONE in Each Column	<input type="checkbox"/> Blue Cross PPO <input type="checkbox"/> Blue Cross Traditional <input type="checkbox"/> Health Alliance Plan (HAP) HMO <input type="checkbox"/> Flexible Blue (High Deductible Health Plan) <input type="checkbox"/> Opt Out / Waive Medical Coverage	<input type="checkbox"/> Blue Cross PPO <input type="checkbox"/> Blue Cross Traditional <input type="checkbox"/> Health Alliance Plan (HAP) HMO <input type="checkbox"/> Flexible Blue (High Deductible Health Plan) <input type="checkbox"/> Opt Out / Waive Medical Coverage
DENTAL Select ONE in Each Column	<input type="checkbox"/> Blue Cross Traditional Dental <input type="checkbox"/> Golden Dental Plan Dental HMO <input type="checkbox"/> Opt Out / Waive Dental Coverage	<input type="checkbox"/> Blue Cross Traditional Dental <input type="checkbox"/> Golden Dental Plan Dental HMO <input type="checkbox"/> Opt Out / Waive Dental Coverage
VISION Select ONE in Each Column	<input type="checkbox"/> Optical Reimbursement Program <input type="checkbox"/> Heritage Vision Plan	<input type="checkbox"/> Optical Reimbursement Program <input type="checkbox"/> Heritage Vision Plan

NOTE: You must also complete an *Enrollment/Change of Status form* to cancel your current coverage and to enroll in your new coverage. (Only one form needed to cancel and to enroll plans and/or eligible dependents).

I am adding one or more dependents to my coverage: Yes No

NOTE: IF YES, attach an *Enrollment/Change of Status form* for the insurance to be in effect on Oct 1st of this year. To add a spouse you must include a marriage certificate. To add a child you must include a birth certificate and, in the case of adoption or guardianship, legal documentation. If the child being added is between the ages of 19 and 25, inclusive, you must also complete a *Verification of No Other Coverage form*. To add other types of dependents, please contact Benefits Administration at (313) 224-7721 or e-mail benefits@co.wayne.mi.us.

I am canceling one or more dependents from my coverage: Yes No

NOTE: IF YES, attach an *Enrollment/Change of Status form* for the insurance to be in effect on Oct 1st of this year. You must provide legal documentation to remove a spouse from your coverage (e.g., divorce decree, death certificate, etc.).

I am a former employee/dependent currently being covered under COBRA: Yes No

I understand that the changes that I have requested will be effective October 1st of this year providing I have been covered by the plan of the County's choice for at least one year by October 1st. I further understand that if the plan elections I make require a contribution towards the cost of the plan as set forth in my labor agreement I hereby authorize that a payroll deduction be commenced in the appropriate amount.

Office Use Only (CC)

Signature Date