WCAA HEALTH BENEFITS ENROLLMENT/CHANGE FORM – NON ACTIVES

DETROIT METRO • WILLOW RUN
WAYNE COUNTY AIRPORT AUTHORITY

Social Security Number	Last Name	First Name	M.I.	Date of Birth Mo Day Yr / /	Sex ☐ Female ☐ Male

Street Address	City	State	Zip Code	Telephone Numbers:
				Daytime ( ) Evening ( )

Please Submit Form To:
Wayne County
Airport Authority
1 L.C. Smith Building
Mezzanine
Detroit, Michigan 48242
FAX TO 734-955-5737

Marital Status: ☐ Single ☐ Married Does your spouse work for WCAA? ☐ Yes ☐ No Do you or dependents have other medical coverage? ☐ Yes ☐ No	Internal Use Only **Old Coverage** Carrier:_____ Group:_____ Eff. Date:_____ Completed by:_____	Internal Use Only **New Coverage** Carrier:_____ Group:_____ Eff. Date:_____ Completed by:_____	Internal Use Only **Old Coverage** Carrier:_____ Group:_____ Eff. Date:_____ Completed by:_____	Internal Use Only **New Coverage** Carrier:_____ Group:_____ Eff. Date:_____ Completed by:_____

Coverage Selection

Medical Plan	Dental Plan
Your Current Plan: ☐ Blue Cross Blue Shield PPO ☐ Opt-Out (Requires Proof of Insurance) ☐ HAP New Plan Selection: ☐ Blue Cross Blue Shield PPO ☐ Opt-out (Requires Proof of Insurance) ☐ HAP	Your Current Plan: ☐ BCBS Dental ☐ Golden Dental ☐ Waived Dental Coverage New Plan Selection: ☐ BCBS Dental ☐ Golden Dental ☐ Waive Dental Coverage

Relation Codes[2]: 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[1] A=Add R=Remove Medical		Dental	Last Name	First Name	M.I.	Social Security Number	Sex	Relation Code[2]	Date of Birth Mo Day Yr	Primary Physician (HAP only) Name/Site/Code
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 ☐ Yes ☐ 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:_____