



# Graduate Student Fellow / Research Affiliate Postdoctoral Fellows Enrollment / Change Application

For Fellowship Holders eligible under SB-29 | Fiscal Year 2020 / 2021

SB-29, which passed during the 2011 legislative session, enables holders of major fellowships (\$10K or more in stipend) to access the university's group medical insurance plan during the months they are on the fellowship. Please note that there is no funding provided by the university to pay the medical premium for the Fellowship recipient. The bill simply grants eligibility to the group medical benefits plan (i.e., basic medical for the fellow and dependents, dental and/or vision insurance). Please complete electronically and/or print clearly and make sure to sign and submit this form to your institution HR/Benefits Office within 31 calendar days of beginning your fellowship. Keep a copy for your records. You may refer to the UT Benefits Handbook and plan guides for details at [www.utsystem.edu/offices/employee-benefits/](http://www.utsystem.edu/offices/employee-benefits/).

A FELLOWSHIP HOLDER						
Name (Last, First, Middle)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<b>HR STAFF USE ONLY</b>	
UT EID	Date of Birth(mm/dd/yyyy)	Social Security Number		Received Date		Received by
Street Address				Effective Date		
City	State		Zip Code	Entered by	Entered Date	
Department		Email			Reviewed by	Reviewed Date
Home Phone		Work phone			Billing	Notified
Citizenship			Race			
<input type="checkbox"/> US Citizen <input type="checkbox"/> Non Resident Alien (United States of America) <input type="checkbox"/> Permanent Resident (United States of America)			<input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> White (Hispanic or Latino) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian, Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander			

**FELLOWSHIP INFORMATION**

**Graduate Student Fellow**

- You may be required to provide a copy of your fellowship paperwork that clearly and specifically indicates the name of the fellow, funding source, begin date and end date.

**Research Affiliate Postdoctoral Fellows**

- You are required to provide a copy of your postdoctoral fellowship paperwork that clearly and specifically indicate the name of the fellow, funding source, begin date and end date.
- You must hold a Research Affiliate – Postdoctoral (Job Code A010) assignment.
- Affiliated Postdoctoral Fellow – Sponsoring Faculty Form** - This form can be found online at [https://hr.utexas.edu/current/insurance/plans/rapostdoc\\_fellow.html](https://hr.utexas.edu/current/insurance/plans/rapostdoc_fellow.html)

**B ENROLLMENT INFORMATION** Select One

**NEW ENROLLMENT**

Name of Fellowship: \_\_\_\_\_

Fellowship Begin Date(mm/dd/yyyy): \_\_\_\_\_ Fellowship End Date(mm/dd/yyyy): \_\_\_\_\_

If your fellowship ends prior to the date above notify the Human Resource Service Center (HRSC) in writing. If your fellowship is extended, notify the HRSC of your extension and provide documentation of your new end date. Email: [hrsc@austin.utexas.edu](mailto:hrsc@austin.utexas.edu)

**CHANGE IN STATUS** (Request for change in coverage must be made within 31 days of qualified event)

Reason: \_\_\_\_\_ Event Date (mm/dd/yyyy): \_\_\_\_\_

Requested Effective Date: (mm/dd/yyyy): \_\_\_\_\_  
(Must be event date, first of the month following event date, or first of the month following election.)

**ANNUAL ENROLLMENT** – Changes made July 15-31 for coverage effective date of September 1.

**C COVERAGE ELECTIONS**

▶ **MEDICAL AND PRESCRIPTION DRUG PLAN**  
Includes: Fellow holder only coverage of \$20,000 Basic Life and \$20,000 Basic Accidental Death and Dismemberment.

**DECLINE MEDICAL** – I do not want this coverage

**UT SELECT PPO Medical**

Select Coverage Level:  Fellow Only  Fellow & Spouse  Fellow & Children  Fellow & Family

**Monthly Premium** \$628.06 \$1,227.68 \$1,121.52 \$1,702.40

**Tobacco Premium Program:** Declare tobacco user(s):  No Tobacco Users  Subscriber  Spouse  Child(ren)<sup>1</sup>

<sup>1</sup> Maximum cost of \$30 per month regardless of how many covered dependent children use tobacco.  
Maximum cost per family is \$90 per month.

**C COVERAGE ELECTIONS (Continued from page 1)** UT EID:

**► VISION** Select One

**NO VISION** – I do not want this coverage

**SUPERIOR VISION**  
 Select Coverage Level:     Fellow Only       Fellow & Spouse       Fellow & Children       Fellow & Family  
**Monthly Premium**      \$5.90                      \$9.30                      \$9.52                      \$15.10

**SUPERIOR PLUS**  
 Select Coverage Level:     Fellow Only       Fellow & Spouse       Fellow & Children       Fellow & Family  
**Monthly Premium**      \$9.00                      \$14.08                      \$15.08                      \$21.30

**► DENTAL** Select One

**NO DENTAL** – I do not want this coverage

**UT SELECT DENTAL**  
 Select Coverage Level:     Fellow Only       Fellow & Spouse       Fellow & Children       Fellow & Family  
**Monthly Premium**      \$28.52                      \$54.14                      \$59.66                      \$84.84

**UT SELECT DENTAL PLUS**  
 Select Coverage Level:     Fellow Only       Fellow & Spouse       Fellow & Children       Fellow & Family  
**Monthly Premium**      \$61.40                      \$116.60                      \$128.66                      \$183.30

**DELTA CARE DENTAL HMO**  
 Select Coverage Level:     Fellow Only       Fellow & Spouse       Fellow & Children       Fellow & Family  
**Monthly Premium**      \$8.80                      \$16.74                      \$18.50                      \$26.40

**D DEPENDENT INFORMATION**

ADD <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D	REMOVE <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D	Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Date of Birth (mm/dd/yyyy)	Social Security Number	Middle Name
				Relationship
ADD <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D	REMOVE <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D	Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Date of Birth (mm/dd/yyyy)	Social Security Number	Middle Name
				Relationship
ADD <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D	REMOVE <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D	Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Date of Birth (mm/dd/yyyy)	Social Security Number	Middle Name
				Relationship

**E AUTHORIZATION, ACKNOWLEDGMENT, AND TPP DECLARATION**

<p><b>State Government Privacy Policy</b>                  With few exceptions, you are entitled to request and to receive and review under Sections 552.021 and 552.023 of the Texas Government Code (the Texas Public Information Act), information that UT System Administration or another UT System institution collects and retains about you. Under Section 559.004, you are entitled to have incorrect information that is retained about you corrected. You can obtain information about how to request access to such information at: <a href="https://advancing.utsystem.edu/privacy-policy">https://advancing.utsystem.edu/privacy-policy</a></p>	<p><b>Notice About Social Security Numbers (SSNs)</b>                  Federal law requires the University of Texas System to report income information and the SSN for all employees to whom compensation is paid. Employee's SSNs are also maintained and used for payroll and benefits and verification purposes as required and permitted by state and federal law. Nonemployee SSNs are requested for use and disclosure for benefits and verification purposes as permitted by state and federal law.</p>
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**Dependent Certification**

By enrolling your Dependents you certify you understand the definition of a Dependent and acknowledge that misrepresentation by an Employee or Retired Employee of benefit eligibility requirements constitutes a violation of OEB official policy and a violation of The University of Texas System Rules and Regulations of the Board of Regents, Series 31013(1). Possible sanctions for such a violation range from a reprimand to dismissal. A Subscriber who enrolls an ineligible Dependent in program coverage may be responsible for reimbursement of prior premiums or claims incurred by the Dependents. A verified misrepresentation by an Employee or Retired Employee shall be reported by OEB to the appropriate institution for investigation and possible sanctions. Deliberate misrepresentation of Dependent eligibility by a Subscriber may constitute criminal fraud and result in a referral to a law enforcement office.

**Definition of Dependent**

For UT SELECT Medical: Your spouse (an individual to whom you are lawfully married, of the opposite or same sex); your child(ren) under age 26 including stepchildren and adopted children; your unmarried grandchild under age 25 if the child qualifies and is claimed as your dependent for federal tax purposes; certain children over age 26 who are determined by OEB to be medically incapacitated and are unable to provide their own support; and children for whom you are named a legal guardian or who are the subject of a medical support order.

For all other UT Benefits: Your spouse (an individual to whom you are lawfully married, of the opposite or same sex); your unmarried child(ren) under age 25 including stepchildren and adopted children; your unmarried grandchild under age 25 if the child qualifies and is claimed as your dependent for federal tax purposes; certain children over age 25 who are determined by OEB to be medically incapacitated and are unable to provide their own support; and children for whom you are named a legal guardian or who are the subject of a medical support order.

**Tobacco Premium Program** "Tobacco Products" includes but is not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip, or any other product that contains tobacco), clove cigarettes and any other smoking devices that use tobacco such as hookahs. E-cigarettes are also included. "Tobacco User" is defined by UT System Office of Employee Benefits as a person who has used tobacco products within the past sixty (60) days. The sixty days are from the day this certification is signed. It is my obligation to submit an amended declaration if I or anyone else declared on this form to be a Non-Tobacco User uses Tobacco Products. I also understand that failure to do so is a violation of the UT SELECT Medical plan rules and UT System policy. I understand that all premium surcharges charges as a Tobacco User will be prospective. I further understand that if I or a dependent subsequently cease to be a Tobacco User, and I submit an amended declaration changing a Tobacco User to a Non- Tobacco User, I will not be refunded any part of the Tobacco User premium surcharges I have already paid.

**Medicare Eligibility** I understand that, whether or not I actually enroll in Medicare, the UT System group health plan (UT SELECT) will be secondary to Medicare when I am eligible for Medicare and not employed in a benefits eligible position with a UT Institution. I also understand that UT strongly recommends that participants who will not be working in a benefits eligible position should enroll in Medicare Parts A and B as soon as they are eligible. Further, I understand that if my dependent(s) are enrolled in UT SELECT and are eligible for Medicare, UT SELECT will be secondary to Medicare for them when I am not working in a benefits eligible position. NOTE: An individual usually becomes eligible for Medicare on the first of the month in which they will turn 65 or sooner due to certain disabilities. For any period in which you and/or your dependents are Medicare eligible and you are not working in a benefits-eligible position, UT SELECT benefits will be reduced by the amount normally paid by Medicare. Please consult your institution's Benefits Office ([www.utsystem.edu/benefits/](http://www.utsystem.edu/benefits/) contacts) or CMS for more information about Medicare eligibility and when to apply.

**Required Documentation for Dependent Enrollment**

TYPE OF DEPENDENT	REQUIRED DOCUMENTS
<b>SPOUSE</b>	<ul style="list-style-type: none"> <li>Valid marriage certificate between subscriber and spouse issued by any state; OR</li> <li>Declaration of Informal Marriage of subscriber and spouse issued by a Texas clerk or utilizing the form promulgated by Texas Department of Health and Human Services; OR</li> <li>Declaration of Informal Marriage issued by another state; OR</li> <li>Other documentation deemed acceptable by OEB</li> </ul>
<b>BIOLOGICAL CHILD</b>	<ul style="list-style-type: none"> <li>Birth Certificate of Child proving relationship to Subscriber; OR</li> <li>Certification of Vital Records proving relationship to Subscriber; OR</li> <li>Verification of Birth Facts Form* proving relationship to Subscriber; OR</li> <li>Valid Medical Support Order requiring Subscriber to provide medical coverage; OR</li> <li>Paternity test* accompanied by Court Order, Medical Support Order, or reissued Birth Certificate</li> </ul>
<b>ADOPTED CHILD</b>	<ul style="list-style-type: none"> <li>Valid Court Order of Adoption; OR</li> <li>Valid Pre-Adoption Placement Order issued by a Licensed Child Placement Agency; OR</li> <li>Valid Court Order naming Subscriber as Managing Conservator of Child; OR</li> <li>Birth Certificate of Child with Adoptive Parent(s); OR</li> <li>Valid Medical Support Order requiring Subscriber to provide medical coverage</li> </ul>
<b>STEPCHILD</b>	<ul style="list-style-type: none"> <li>Birth Certificate of Child; AND</li> <li>Marriage Certificate of Subscriber and Spouse (Biological Parent)</li> </ul>
<b>FOSTER CHILD</b>	<ul style="list-style-type: none"> <li>Valid Court Order establishing a parent-child relationship between Subscriber and Foster Child</li> </ul>
<b>GRANDCHILD</b>	<ul style="list-style-type: none"> <li>Birth Certificate of Grandchild or Verification of Birth Facts Form* proving relationship to Subscriber; AND</li> <li>Birth Certificate of Biological Parent; AND</li> <li>Grandchild Certification Form*; AND</li> <li>Most recent tax return indicating Grandchild is the financial dependent of Subscriber</li> </ul>
<b>INCAPACITATED OVER AGE DEPENDENT</b>	<ul style="list-style-type: none"> <li>Valid Document (e.g., birth certificate, adoption papers) proving relationship to Subscriber; AND</li> <li>Application For Coverage of Incapacitated Over Age Dependent Form*; AND</li> <li>Supporting Medical Records Less Than One Year Old*</li> </ul>
<b>WARD</b>	<ul style="list-style-type: none"> <li>Valid Court Order naming Subscriber as Guardian or Conservator</li> </ul>

**IMPORTANT**  
 1. A Power of Attorney is not adequate legal documentation for establishing a Dependent relationship. 2. A complete copy (all pages) of a Court Order may be required to be provided, depending on eligibility and documentation requirements. 3. If Subscriber is unable to provide the above document(s) but has other documentation that may establish a Dependent relationship, the institution HR Manager should review and determine that the alternative documentation is adequate. 4. A document in a language other than English must be accompanied by a notarized, sworn affidavit by an independent third party indicating the document has been reviewed and translated.

**By signing this form, I agree to timely pay for all coverages set forth on this form in which I have elected to enroll and to otherwise comply with the UT System Uniform Group Insurance Program rules and Texas Insurance Code Chapter 1601. I also confirm that all information I have provided on this form is correct to the best of my knowledge; and, that I have read and understand all of the notices provided on this form.**

Signature \_\_\_\_\_ Date(mm/dd/yyyy) \_\_\_\_\_

This application MUST be signed and submitted to your institution Benefits Office for processing. Submission of application does not guarantee enrollment. You may be required to complete a Dependent Information form, Evidence of documentation.