UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

Enrollment / Change Application

FOR EMPLOYEES - **EFFECTIVE ON OR AFTER SEPTEMBER 1, 2019**

Please complete electronically and/or print clearly and make sure to sign and submit this form to your institution HR/Benefits Office. 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/**

A EMPLOYEE INFORMATION

Name (Last, First, Middle)			**HR STAFF USE ONLY** Purpose of this application: To enroll in or change UT Benefits Coverage.	
Employee ID/Benefits ID (BID)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	Benefits Representative	
Street Address			E-mail Address or Phone Number	
City	State	Zip Code	Effective Date (mm/dd/yyyy)	Date Entered (mm/dd/yyyy)
Home Phone	Work Phone		UT FLEX Effective Date (If Different)	
Department			Reviewed By (Initials)	

B ENROLLMENT INFORMATION

☐ **NEW EMPLOYEE- DATE OF HIRE: Check all that may apply:**
- ☐ have been employed by the following UT institution or State of Texas agency within the past 31 days:
- ☐ have participated in the Teacher Retirement System (TRS) and ☐ **have** ☐ **have not** withdrawn my account.
- ☐ have participated in the State of Texas Optional Retirement Program (ORP) with the following agency/institution:
- ☐ am retired from a State of Texas plan: ☐ TRS ☐ ERS ☐ ORP Retirement date:

☐ **CHANGE IN STATUS- REASON:** Choose one:

Event Date (mm/dd/yyyy)**:** (Request for coverage must be made within 31 days of qualified event.)

Coverage Effective Date (mm/dd/yyyy)**:** (Must be first of month following event unless an exception has been approved.)

☐ **ANNUAL ENROLLMENT-** Coverage effective date will be September 1.

EMPLOYMENT STATUS

☐ **FULL-TIME** ☐ **PART-TIME-** I understand that the University will only pay a portion of my premiums, and the remainder due will be deducted from my paycheck.

C COVERAGE ELECTIONS

MEDICAL AND PRESCRIPTION DRUG PLAN

Includes $40,000 Basic Life and $40,000 Basic AD&D coverage for the employee at no additional cost.

☐ **UT SELECT PPO Medical**
Select Coverage Level : ☐ Employee Only ☐ Emp & Spouse ☐ Emp & Children ☐ Emp & Family
Estimated Monthly Premium $ 0.00

☐ **UT SELECT PPO Medical - Part Time**
Select Coverage Level : ☐ Employee Only ☐ Emp & Spouse ☐ Emp & Children ☐ Emp & Family
Estimated Monthly Premium $ 0.00

☐ **UT CONNECT ACO Medical**
Select Coverage Level : ☐ Employee Only ☐ Emp & Spouse ☐ Emp & Children ☐ Emp & Family
Estimated Monthly Premium $ 0.00

☐ **UT CONNECT ACO Medical - Part Time**
Select Coverage Level : ☐ Employee Only ☐ Emp & Spouse ☐ Emp & Children ☐ Emp & Family
Estimated Monthly Premium $ 0.00

Tobacco Premium Program: Declare tobacco user(s): ☐ No Tobacco Users ☐ Subscriber ☐ Spouse ☐ Child(ren)[1]
[1] *Maximum cost of $30 per month regardless of how many covered dependent children use tobacco.*
[2] *Maximum cost per family is $90 per month.*

Tobacco Surcharge [2] $ 0.00

☐ **Waive Coverage-** I understand I may apply a percentage of the premium-sharing dollars to which I am entitled toward other optional insurance coverage. Proof of other medical insurance is required.

☐ **Decline Coverage-** I understand I will not receive premium-sharing dollars to which I may be entitled.

* UT CONNECT is an Accountable Care Organization medical plan available in Dallas Fort Worth area only.

COVERAGE ELECTIONS (CONTINUED FROM PAGE 1)

▸ VISION SELECT ONE:

☐ **Superior Vision** — Estimated Monthly Premium
Select Coverage Level : ☐Employee Only ☐Emp & Spouse ☐Emp & Children ☐Emp & Family — $ 0.00

☐ **Superior Vision Plus**
Select Coverage Level : ☐Employee Only ☐Emp & Spouse ☐Emp & Children ☐Emp & Family — $ 0.00

☐ **No Coverage**

▸ DENTAL SELECT ONE:

☐ No Coverage	☐ UT SELECT Dental	☐ UT SELECT Dental Plus	☐ DeltaCare Dental HMO
	☐Employee Only ☐Emp & Spouse ☐Emp & Children ☐Emp & Family	☐Employee Only ☐Emp & Spouse ☐Emp & Children ☐Emp & Family	☐Employee Only ☐Emp & Spouse ☐Emp & Children ☐Emp & Family
Estimated Monthly Premium:	$ 0.00	$ 0.00	$ 0.00

▸ GROUP TERM LIFE INSURANCE $40,000 basic coverage is provided at no cost if employee is enrolled in UT SELECT or UT CONNECT Medical Plan. EOI may be required for voluntary cov'g.

VOLUNTARY EMPLOYEE COVERAGE — Estimated Monthly Premium

☐ **Annual Earnings Times:** 0 to 10 times - Not to exceed $2 million) ☐ **No Voluntary Coverage for Employee** $

Evidence of insurability (EOI) is required when new employees enroll in 4-10x annual earnings
OR when coverage is added or increased due to Change in Status or during Annual Enrollment.

VOLUNTARY DEPENDENT COVERAGE

Employee must have voluntary coverage of at least 1x annual earnings to be eligible for Voluntary Dependent coverage.

☐ **$10,000 per Dependent** - Spouse & Children

☐ **$25,000 Spouse and $10,000 per Child -** Evidence of Insurability (EOI) is required.

☐ **$50,000 Spouse and $10,000 per Child -** Evidence of Insurability (EOI) is required.

☐ **No Voluntary Coverage for Dependent(s)**

▸ ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) $40,000 basic coverage is provided at no cost if employee is enrolled in UT SELECT or UT CONNECT Medical Plan.

VOLUNTARY EMPLOYEE COVERAGE

☐ **Maximum of 10 times annual earnings** - Not to exceed $2,000,000.

☐ **Fixed Amount $** $10,000 increments up to 10 times employee earnings or $2,000,000 whichever is less.

☐ **No Voluntary Coverage for Employee**

VOLUNTARY DEPENDENT COVERAGE

Employee must have voluntary coverage of at least $20,000 voluntary coverage to be eligible for Voluntary Dependent coverage.

☐ **Child(ren):** $10,000 per each eligible dependent child

AND / OR

☐ **Spouse, Maximum -** 50% of employee voluntary coverage.

☐ **Spouse, Fixed Amount $** $10,000 increments up to 50% employee coverage.

☐ **No Voluntary Coverage for Dependent(s)**

▸ SHORT-TERM DISABILITY (STD) Evidence of Insurability may be required.

Monthly Premium= $0.0027 x basic monthly earnings (includes salary, longevity & hazard pay but cannot exceed $5,000). To calculate basic monthly earnings, divide annual contract salary by 12 months.

☐ **Short-Term Disability** ☐ **No Coverage**

▸ LONG-TERM DISABILITY (LTD) Evidence of Insurability may be required.

Monthly Premium= $0.0038 x basic monthly earnings (includes salary, longevity & hazard pay but cannot exceed $20,042). To calculate basic monthly earnings, divide annual contract salary by 12 months.

☐ **Long-Term Disability** ☐ **No Coverage**

COVERAGE ELECTIONS (CONTINUED FROM PAGE 2)

UT FLEX FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE REIMBURSEMENT ACCOUNT

☐ **Yearly Deduction of $ based on a -- monthly pay period.** The Maestro Debit Card is provided to all participants at no charge.

The Plan Year maximum election is $2,700; minimum is $180. Monthly deductions will be made based on number of paychecks employee receives during the Plan Year.

☐ **No Enrollment in the Health Care FSA**

DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

☐ **Yearly Deduction of $ based on a -- monthly pay period.**

The Calendar Year maximum election is $5,000; minimum is $180. Monthly deductions will be made based on number of paychecks employee receives during the Plan Year.

☐ **No Enrollment in the Dependent Day Care FSA**

D DEPENDENT INFORMATION

ADD ☐Medical ☐Dental ☐Vision ☐Life ☐AD&D	**REMOVE** ☐Medical ☐Dental ☐Vision ☐Life ☐AD&D	Last Name Date of Birth (mm/dd/yyyy)	First Name Social Security Number	☐ Male ☐ Female Middle Name Choose from list: Relationship
ADD ☐Medical ☐Dental ☐Vision ☐Life ☐AD&D	**REMOVE** ☐Medical ☐Dental ☐Vision ☐Life ☐AD&D	Last Name Date of Birth (mm/dd/yyyy)	First Name Social Security Number	☐ Male ☐ Female Middle Name Choose from list: Relationship
ADD ☐Medical ☐Dental ☐Vision ☐Life ☐AD&D	**REMOVE** ☐Medical ☐Dental ☐Vision ☐Life ☐AD&D	Last Name Date of Birth (mm/dd/yyyy)	First Name Social Security Number	☐ Male ☐ Female Middle Name Choose from list: Relationship

Required Documentation for Dependent Enrollment

TYPE OF DEPENDENT	REQUIRED DOCUMENTS
SPOUSE	• Valid marriage certificate between subscriber and spouse issued by any state; OR • 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 • Declaration of Informal Marriage issued by another state; OR • Other documentation deemed acceptable by OEB
BIOLOGICAL CHILD	• Birth Certificate of Child proving relationship to Subscriber; OR • Certification of Vital Records proving relationship to Subscriber; OR • Verification of Birth Facts Form* proving relationship to Subscriber; OR • Valid Medical Support Order requiring Subscriber to provide medical coverage; OR • Paternity test* accompanied by Court Order, Medical Support Order, or reissued Birth Certificate
ADOPTED CHILD	• Valid Court Order of Adoption; OR • Valid Pre-Adoption Placement Order issued by a Licensed Child Placement Agency; OR • Valid Court Order naming Subscriber as Managing Conservator of Child; OR • Birth Certificate of Child with Adoptive Parent(s); OR • Valid Medical Support Order requiring Subscriber to provide medical coverage
STEPCHILD	• Birth Certificate of Child; AND • Marriage Certificate of Subscriber and Spouse (Biological Parent)
FOSTER CHILD	• Valid Court Order establishing a parent-child relationship between Subscriber and Foster Child
GRANDCHILD	• Birth Certificate of Grandchild or Verification of Birth Facts Form* proving relationship to Subscriber; AND • Birth Certificate of Biological Parent; AND • Grandchild Certification Form*; AND • Most recent tax return indicating Grandchild is the financial dependent of Subscriber
INCAPACITATED OVER AGE DEPENDENT	• Valid Document (e.g., birth certificate, adoption papers) proving relationship to Subscriber; AND • Application For Coverage of Incapacitated Over Age Dependent Form*; AND • Supporting Medical Records Less Than One Year Old*; AND • Most recent tax return indicating child is financial dependent of subscriber.
WARD	• Valid Court Order naming Subscriber as Guardian or Conservator
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.

Signature is required to complete this application. Continue to Section E ▸

E AUTHORIZATION, ACKNOWLEDGMENT, AND TPP DECLARATION

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.

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 the Office of Employee Benefits 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
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 grandchild under age 26 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.

A Dependent does not mean anyone who is on active duty in the armed forces of any country (for coverage other than UT SELECT Medical). A dependent that has coverage under any plan for which the dependent already receives a premium sharing contribution from the State of Texas is not eligible for premium sharing under the UT SELECT plan. This includes any Employee, Retiree or Dependent coverage under another University of Texas or Texas A&M plan, and any plan offered by a Texas state agency, and certain public school districts.

Notice About Social Security Numbers (SSNs)
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.

State Government Privacy Policy
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: www.utsystem.edu/ogc/openrecords/access.htm.

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/offices/employee-benefits/contacts) or CMS for more information about Medicare eligibility and when to apply.

UT FLEX Reimbursement Accounts
If I elect to participate in the UT FLEX account(s), I also authorize The University of Texas System to redirect (reduce) my taxable pay by the indicated amounts.

I understand and agree that:

- I cannot change or suspend my election during the plan year period for any reason other than a qualifying statutes change.
- I cannot transfer money between the reimbursement accounts.
- Any money in my account(s) not claimed by November 30th for a qualified expense incurred during the plan year will be forfeited. The plan year for the Health Care Account has a "grace period" which extends the period of time to incur an expense from September 1 to November 15 while the Dependent Account plan year remains September 1 – August 31.

The redirections I have elected are made in accordance with the UT FLEX summary booklet and the provisions of the Internal Revenue Code Section 125, and will be taken out in equal installments throughout the plan year.

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 iscorrect to the best of my knowledge; and, that I have read and understand all of the notices provided on this form.

Employee 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.