UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

Enrollment / Change Application

FOR RETIRED EMPLOYEES - **EFFECTIVE ON OR AFTER SEPTEMBER 1, 2020**

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 RETIRED 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		Reviewed By (Initials)	
Department				

B ENROLLMENT INFORMATION

☐ **NEW RETIRED EMPLOYEE- EFFECTIVE DATE:** **Check all that may apply:**

☐ I have been employed by the following UT institution or State of Texas agency within the past 31 days:

☐ I have participated in the Teacher Retirement System (TRS) and ☐ **have** ☐ **have not** withdrawn my account.

☐ I have participated in the State of Texas Optional Retirement Program (ORP) with the following agency/institution:

☐ I 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.

C COVERAGE ELECTIONS

MEDICAL AND PRESCRIPTION DRUG PLAN

Includes $6,000 Basic Life for the retiree at no additional cost.

☐ **UT SELECT PPO Medical** Select Coverage Level:
☐ Retiree Only **$0** ☐ Ret & Spouse **$270.42** ☐ Ret & Children **$282.82** ☐ Ret & Family **$532.52**

Estimated Monthly Premium $ 0.00

☐ **UT CONNECT ACO Medical*** Select Coverage Level :
☐ Retiree Only **$0** ☐ Ret & Spouse **$243.38** ☐ Ret & Children **$254.54** ☐ Ret & Family **$479.26**

Estimated Monthly Premium $ 0.00

Tobacco Premium Program: Declare tobacco user(s): ☐ No Tobacco Users ☐ Subscriber **$30** ☐ Spouse **$30** ☐ Child(ren) **$30**[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 for non-Medicare eligible Retirees only.

COVERAGE ELECTIONS (CONTINUED FROM PAGE 1)

VISION SELECT ONE:

☐ **Superior Vision** Select Coverage Level :
☐Retiree Only **$5.90** ☐Ret & Spouse **$9.30** ☐Ret & Children **$9.52** ☐Ret & Family **$15.10**

Estimated Monthly Premium $ 0.00

☐ **Superior Vision Plus** Select Coverage Level :
☐Retiree Only **$9.00** ☐Ret & Spouse **$14.08** ☐Ret & Children **$15.08** ☐Ret & Family **$21.30**

Estimated Monthly Premium $ 0.00

☐ **No Coverage**

DENTAL SELECT ONE:

☐ **No Coverage**	☐ **UT SELECT Dental**	☐ **UT SELECT Dental Plus**	☐ **DeltaCare Dental HMO**
	☐ Retiree Only **$28.52**	☐ Retiree Only **$61.40**	☐ Retiree Only **$8.80**
	☐ Ret & Spouse **$54.14**	☐ Ret & Spouse **$116.60**	☐ Ret & Spouse **$16.74**
	☐ Ret & Children **$59.66**	☐ Ret & Children **$128.66**	☐ Ret & Children **$18.50**
	☐ Ret & Family **$84.84**	☐ Ret & Family **$183.30**	☐ Ret & Family **$26.40**
Estimated Monthly Premium:	$ 0.00	$ 0.00	$ 0.00

GROUP TERM LIFE INSURANCE

$6,000 basic coverage is provided at no cost if retiree is enrolled in UT SELECT or UT CONNECT Medical Plan. EOI may be required for voluntary cov'g.

VOLUNTARY RETIREE COVERAGE

☐**$7,000** ☐**$10,000** ☐**$25,000** ☐**$50,000** ☐**$100,000** ☐**No Voluntary Coverage for Retiree**

VOLUNTARY DEPENDENT COVERAGE

Retiree Voluntary Life coverage is required to elect Spouse Voluntary Life coverage. Evidence of Insurability may be required.

☐ **$3,000 Spouse Coverage**

☐ **No Voluntary Coverage for Spouse**

D DEPENDENT INFORMATION

ADD	REMOVE			
☐Medical ☐Dental ☐Vision ☐Life	☐Medical ☐Dental ☐Vision ☐Life	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	**REMOVE** ☐Medical ☐Dental ☐Vision ☐Life	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	**REMOVE** ☐Medical ☐Dental ☐Vision ☐Life	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.

Insurance Benefits Eligibility
I understand that I am only eligible to participate in UT System group employee health and other insurance benefits as a retiree if I retire as an annuitant from the Teacher Retirement System (TRS) or the Employees Retirement System (ERS): or if I am a member of the Optional Retirement Program (ORP) established by Chapter 830, Government Code, if I have completed an ORP Declaration of Retirement form. I further understand that if I fail to complete the retirement process and/or fail to receive annuity through TRS or ERS, I will not be eligible for UT System group insurance benefits as a retiree. I also understand that it is my responsibility to notify my UT System institution benefits office if I fail to either become a TRS or ORP annuitant, or sign the ORP Declaration of Retirement form; and that my failure to do so may constitute insurance fraud.

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.

Retired 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.