Print Form Clear Fields

HR 102 (7/16)

System Member: _____

The Texas A&M University System
Annual Enrollment Form

With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form.

* A E F *

1. Name _____ 2. ___ – ___ – ____
   Last (please print) First MI UIN or Social Security number
3. Home address _____
   Street Address City State ZIP code
4. If you have a spouse/parent/child who currently works for The Texas A&M University System, please provide his/her name _____ and UIN/Social Security number _____

TOBACCO USE **Office use only: ED** _____

5. I have ☐ have not ☐ used tobacco products within the last 3 months.

HEALTH **Office use only: ED** _____

To add or drop dependents, you must complete a Dependent Enrollment/Change Form (HR 101).

6. I want to enroll in the following health plan: _____
   (Complete a Beneficiary Designation Form for Basic Life, if applicable)
7. I want to cancel my System health coverage _____
8. If cancelling, I have other health coverage. Yes ☐ No ☐ (If no, go to question 10).
9. If yes, I have other health insurance through (pick one of the following, then skip question #10):
   - An A&M System-offered plan as a dependent ☐
   - A state-provided plan such as the Employees Retirement System or University of Texas System as a former employee ☐ (if yes, skip to #13.)
   - A state-provided plan such as the Employees Retirement System or University of Texas System as a dependent ☐
   - Another company, affiliation plan or Medicare, Medicaid or other government-offered plan ☐
10. I want to keep Basic Life coverage, but I understand that I must pay for this coverage myself. Yes ☐ No ☐ (Proceed to the next section in which you wish to make changes on this form.)
11. I want to enroll in Alternate Basic Life. Yes ☐ No ☐ (If you answer yes, complete #12) You must also complete a Beneficiary Designation Form. *If you currently have no life insurance or only $7,500 in coverage, you will need to provide evidence of good health to increase coverage to $50,000.*
12. I want half of the employee-only employer contribution applied to the premiums for Alternate Basic Life, dental, vision, Accidental Death and Dismemberment and Long-Term Disability, if I am enrolled in these coverages. Yes ☐ No ☐

If you do not have A&M System health coverage but certify that you have other health coverage, you may enroll in Alternate Basic Life or Optional Life, but not both.

DENTAL **Office use only: ED** _____

To *add or drop dependents (unless cancelling all coverage), you must complete a Dependent* Enrollment /Change Form (HR 101).

13. I want to enroll in/change to A&M Dental ☐ Dental HMO ☐
14. I want to cancel coverage for myself and *all* covered dependents ☐

VISION **Office use only: ED** _____

To *add or drop dependents (unless cancelling all coverage), you must complete a Dependent* Enrollment /Change Form (HR 101).

15. I want to enroll ☐
16. I want to cancel coverage for myself and *all* covered dependents ☐

OPTIONAL LIFE **Office use only: ED** _____

You may not enroll in Optional Life if you are covered under Dependent Life by a spouse who works for The Texas A&M University System or if you are enrolled in Alternate Basic Life. **Retirees** *must provide evidence of good health to enroll in or increase their Optional Life coverage.* **Employees** *must provide evidence of good health if enrolling, increasing* coverage or choosing a *coverage amount of* four, *five or six times salary.*

18. Employee: I want to decrease coverage to (check one):
    ½ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ times my annual salary.
19. Retiree: I want to *decrease* coverage to $ _____
    (amount must be more than $5000, and it must be a multiple of $1,000)
20. I want to cancel my coverage _____

Date Stamp

DEPENDENT LIFE **Office use only: ED _____**

You may not enroll your spouse if your spouse has Optional Life or Alternate Basic Life coverage as an employee of The Texas A&M University System. To drop dependents (unless you're cancelling all coverage), you must complete a Dependent Enrollment/Change Form. To enroll dependents or switch from Dependent Life Plan B to Plans A or C, you must provide evidence of good health.

20. I want to change to the flat rate Plan B ☐
21. I want to cancel all Dependent Life Coverage ☐

ACCIDENTAL DEATH AND DISMEMBERMENT **Office use only: ED _____**

22. Plan option: Employee coverage ☐ Family coverage ☐
23. Coverage amount of: $_____. (Limited to the greater of $250,000 or 10 times your Sept. 1, 2017 salary, not to exceed $800,000.)
24. I want to cancel my coverage. ☐
25. I am enrolling in AD&D coverage for the first time, and I have designated the following beneficiaries (attach an additional sheet if necessary):

Primary Beneficiary(ies)

Name	*Relationship*	*Distribution by %*	*Address (Street/P.O. Box, City, State, ZIP)*

Secondary Beneficiary(ies)

Name	*Relationship*	*Distribution by %*	*Address (Street/P.O. Box, City, State, ZIP)*

LONG-TERM DISABILITY* **Office use only: ED _____**

26. I want to enroll in coverage. ☐
27. I want to cancel my coverage. ☐

*Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician, received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.

FLEXIBLE SPENDING ACCOUNTS **Office use only: ED _____**

For employees working less than 12 months, 4 months of deductions will be taken in May.

		Monthly Amount	Annual Total
28. Health Care Account	☐		
29. Dependent Day Care Account:	☐		

Health Care: Monthly minimum $20, annual max $2,600. Dependent Day Care: Monthly minimum $40, annual max $5,000 ($2,500 max if married and filing separate income tax return.

30. I do ☐ do not ☐ want my Spending Account reimbursements deposited directly into the same account as my paycheck.
31. I want to cancel my: Health Care Account ☐ Depdendent Day Care Account ☐

If enrolling in a Health Care Account, you will automatically receive a debit card. There is no cost to the participant for the debit card. If you cancel participation in a Health Care Account, only eligible charges with a date of service before the cancellation are reimbursable

Read the following agreements and sign below.

Payroll Deduction/Billing Agreement: If I am being billed, I understand that failure to pay my premium(s) will result in cancellation of coverage.

Insurance Cancellation Agreement: If cancelling any insurance coverage, I understand that in order to participate in the future I may be required to furnish evidence of good health at my own expense. Coverage is subject to the carrier's approval and is not guaranteed. In addition, for certain plans I may enroll only during certain enrollment periods and/or be subject to pre-existing condition limitations.

Release of Information: I understand that certain information collected using this form will be sent to the insurance carriers of the plans in which I enroll. The A&M System and the insurance carriers will treat this information as confidential. .

Tobacco User Agreement: I understand that if I have indicated on this form that I am not a tobacco user and this proves to have been a false statement, my coverage and any associated dependent benefit coverage may be cancelled.

If you are designating beneficiaries, this form must be witnessed. The date of the witness' signature must be the same as yours. The witness cannot be a beneficiary or your relative.

Original Signature Required

Signature of witness in ink (blue preferred)

Witness's name (printed)

Date (MM/DD/YYYY)

Original Signature Required

Signature of employee/retiree in ink (blue preferred)

Daytime phone number

Signature Date (MM/DD/YYYY)