Print Form Clear Fields

**HR 107 (04/16)**

System Member ____
Check one:
TRS ☐
ORP ☐

# The Texas A&M University System
# Retiree Benefit Enrollment Form

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

* R B F *

1. _____ _____ ____
*Last (please print)* *First* *MI*

___ – ___ – ____
*UIN or Social Security number*

3. Retirement date ____/____/____ 4. Birthdate ____/____/____
*Month Day Year* *Month Day Year*

5. (____) _____
*Phone number*

6. We would like to continue providing your benefit information, including annual enrollment notices, to you via email. Will you agree to receive this information electronically? Yes ☐ No ☐ If yes, please provide a non-work email address _____

7. Address _____ _____ ____ _____
*City* *State* *ZIP*

8. If you have a spouse who is an employee or retiree of The Texas A&M University System, please provide his/her Name _____ UIN/Social Security number _____

Some of your benefits will change upon retirement. **To continue dependent coverage, you must complete a new Dependent Enrollment/Change Form (HR 101).** To ensure that your life insurance beneficiary information is current, complete a Beneficiary Designation Form or update the information through the Beneficiary Database in *iBenefits* at https://sso.tamus.edu. If you are a former employee who is returning to regain insurance coverage, you must provide documentation of an intact TRS/ORP account and, if you are in TRS, evidence that you are receiving or have applied to receive your annuity payments. You must complete and return this form to your Human Resources office within 60 days after leaving a TRS-eligible position or becoming eligible for retirement insurance benefits or during Annual Enrollment.

9. I have ☐ have not ☐ used any tobacco products within the past 3 months.

## HEALTH

**Office use: ED** _____

- *If you are 65 or older and will not continue working for The Texas A&M University System, Medicare will become your primary payerfor your insurance (and your spouse's insurance if he/she is also 65 or older). However, if you begin the A&M System employment, and are not working at least 50% time, for at least 4 1/2 consecutive months, Medicare will be your primary payer. If you are working more than 50% time for 4 1/2 consecutive months or more, you cannot enroll in the 65PLUS plan.*
- *You are eligible for the A&M Care 65PLUS plan if you are retired and you and any covered dependents are disabled or 65 or olderand enrolled in Parts A and B of Medicare. (Any time worked in a month counts as having worked the full month.)*

10. I wish to remain enrolled in my current coverage (please state name of plan) _____.
11. I am enrolled in an A&M health plan and wish to change to: A&M Care 65PLUS ☐ A&M Care ☐
*If you elect 65PLUS, please provide a copy of your Medicare card.*
12. I am currently not enrolled in health coverage *or* I am a former A&M System employee returning to retire with the System and I wish to enroll in the following health plan: _____
13. I am a former employee, and I want my chosen coverage to begin:
☐ the first of the month after the day on which my Human Resources office receives this form
☐ on my employer contribution eligibility date (first of the month following the 90th day after you apply for benefits)
14. I do not want coverage/I wish to cancel coverage ☐. (If so, proceed to #15. Otherwise, proceed to #20.)

## BASIC LIFE/ALTERNATE BASIC LIFE

**Office use: ED** _____

*If you are enrolled in a System health plan, or if you are not enrolled but have Basic Life or Alternate Basic Life, your Basic Life/ Alternate Basic Life coverage will continue automatically and remain the same. In this case, you do not need to complete this section.*

15. I certify ☐ do not certify ☐ that I have other health coverage.

*If you certify that you have other health coverage, you may enroll in Alternate Basic Life coverage (#17). On your employer contribution eligibility date, half of the employee-only contribution will be applied to premiums for the following coverages, if you are enrolled: Alternate Basic Life, Accidental Death and Dismemberment, dental and vision. If you do not certify that you have other health coverage, you may purchase Basic Life coverage (#18), but you are not eligible for the employer contribution. You may not enroll in both Alternate Basic Life and Optional Life.*

16. I have other health insurance through (pick one of the following):
An A&M system-offered plan as a dependent ☐
A state-provided plan such as the Employee Retirement System or University of Texas System as a former employee ☐
A state-provided plan such as the Employee Retirement System or University of Texas System as a dependent ☐
Another company, affiliation plan or Medicare, Medicaid or other government-offered plan ☐
17. I wish to enroll in Alternate Basic Life coverage. Yes ☐ No ☐ (If yes, complete a Beneficiary Designation Form and proceed to #20. If no, proceed to #20.)
18. I wish to purchase Basic Life coverage. Yes ☐ No ☐ (If yes, complete a Beneficiary Designation Form.)
19. I wish to cancel my Basic/Alternate Basic Life coverage. ☐

Date Stamp

Office use: ED _____

**EFFECTIVE DATE OF OPTIONAL COVERAGES (FOR FORMER EMPLOYEES ONLY):**

20. I want the coverages I've selected on page 2 to begin:
    - ☐ the first of the month after the day on which my Human Resources office receives this form
    - ☐ on my employer contribution eligibility date (first of the month following the 90th day after you apply for benefits)

**DENTAL**

Office use: ED _____

21. I wish to remain enrolled in my current coverage, which is: A&M Dental ☐ Dental HMO ☐.
22. I wish to change to A&M Dental ☐ Dental HMO ☐.
23. I am a former A&M System employee returning to retire with the A&M System and I wish to enroll in A&M Dental ☐ Dental HMO ☐.
24. I wish to cancel my A&M Dental or Dental HMO coverage _____.

Office use: ED _____

**VISION**

25. I am currently enrolled and wish to keep my coverage as is ☐.
26. I am a former A&M System employee returning to retire with the A&M System and I wish to enroll ☐.
27. I wish to cancel my coverage ☐.

**OPTIONAL LIFE** Office use: ED _____

*If you are younger than age 70, the maximum coverage amount is $100,000 or your current coverage level, whichever is less. If you are age 70 or older, your maximum coverage level is $60,000. If you are age 80 or older, your maximum coverage level is $30,000. Retirees must always provide E of I to enroll in or increase coverage. If enrolled, you must complete a new Beneficiary Designation Form.*

28. Based on the limitation above, I want $_____ of coverage.
29. I wish to cancel coverage _____. In addition, I certify that I do not have A&M System health coverage, but I do have other health coverage. Please move my current Optional Life coverage amount (up to $50,000) to Alternate Basic Life so it will be paid for by the employer contribution. Yes ☐ No ☐

**DEPENDENT LIFE** Office use: ED _____

*If you have Plan A, the coverage amount may change to reflect a maximum of $50,000, if you are under age 70 at retirement, a maximum of $30,000 if you are age 70 or older, and a maximum of $15,000 if you are age 80 or older. If you have Plan B, the coverage amount will remain $5,000 for each covered dependent. If you have Plan C, your coverage won't change. Under this coverage, you are the primary beneficiary. To name a secondary beneficiary, complete a Beneficiary Designation Form.*

30. I wish to stay enrolled in the same plan, although I understand the coverage amount may decrease _____.
31. I wish to change from Plan A or C to Plan B __ (You must provide evidence of insurability to enroll or to move from Plan B to Plan A or C.)
32. I wish to cancel coverage _____.

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

*If you are younger than 70, your maximum coverage amount is $200,000. If you are age 70 or older, your maximum coverage amount is $60,000. In addition, your premium will automatically increase when you retire. If enrolled, you must complete a new Beneficiary Designations.*

33. I want coverage in the amount of $_____
34. I want individual _____ family _____ coverage.
35. I want to cancel coverage on myself (if you have family coverage, it will also be cancelled) _____, or on my family only. _____

**LONG-TERM DISABILITY** *You are no longer eligible for this plan.*

**After completing your changes, read the following agreements and sign below.**

**Billing Agreement:** I authorize The Texas A&M University System to bill me or draft my bank account to cover my share of the premiums for these coverages. I understand that failure to pay my premium(s) will result in cancellation.

**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 insurability at my own expense. Coverage is subject to the carrier's approval and is not guaranteed. In addition, I may enroll in some plans only during specified enrollment periods. Benefits will be paid based on coverage records in my insurance file and in accordance with the terms of the applicable group policy.

**Release of Information:** I understand that certain information collected by the A&M System, including some collected using this form, must be sent to the carriers of the plans in which I have enrolled. 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.

Original Signature Required _____ _____ ___ ___ – ___ ___ – ___ ___ ___ ___

***Signature of retiree in ink (blue preferred)*** *Daytime phone number* *Signature date (MM–DD–YYYY)*