Print Form Clear Fields

HR 100 (7/16)
System Member ____
Hire date ____
Employer contribution
Eligibility date ____

The Texas A&M University System

New Employee Benefit Enrollment Form

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

* N E F *

1. Name ____ ____ ____ 2. ____ – ____ – ____
Last (please print) First MI UIN or Social Security number

3. Birthdate ____/____/____ 4. Address ____ ____ ____ ____
mo. day yr. Street City State ZIP

5. If you have a spouse/parent/child who currently works for or is retired from The Texas A&M University System, please provide his/her name ____ and UIN/Social Security number ____ and check here ___ if you are transferring from his/her coverage to your own.
6. Do you have an intact ORP or TRS account? Yes ☐ No ☐
7. Are you transferring employment from another state agency or institution with no break in service? Yes ☐ No ☐
8. Are you already retired from another state agency or institution? Yes ☐ No ☐

An employee may not receive employer contribution from two state institutions at the same time.

Instructions: For each coverage, check the enroll block or, if you do not want that coverage or if you are unsure, the defer/waive block. If enrolling, complete the information for that coverage. You have 60 days from your hire date to add, drop or change coverages using a Benefit Change Form.

OPTIONS: *(if you do not designate, the "default" for #10 is tobacco user.)* **Office use: ED** _____

9. Your health/dental/vision/AD&D premiums will automatically be deducted from your pay on a before-tax basis. This will increase your take-home pay.
10. I have ☐ have not ☐ used any tobacco products within the past 3 months.

HEALTH: ☐ **Enroll** ☐ **Waive (if you check waive, go to #13)** **Office use: ED** _____

To enroll dependents, you must complete a Dependent Enrollment/Change Form/Certification.

Please allow 7 business days processing time to carrier before scheduling appointments or receiving prescriptions.

You are automatically enrolled in A&M Care on your employer contribution eligibility date. If you wish to enroll in a different health plan, complete this form and return it to your Human Resources office. You may choose to make your health coverage effective before your employer contribution eligibility date, but you will pay the full premium until you become eligible for the employer contribution.

11. I wish to enroll in: A&M Care ☐ *OR* the following health plan ____
12. I understand that A&M Care coverage automatically begins on my employer contribution eligibility date unless I waive coverage or select a different coverage. I want my A&M Care or other chosen coverage to begin:
    - ☐ on my date of hire if I am signing this form on, before or within seven days of my hire date
    - ☐ the first of the month after the day on which my Human Resources office receives this form
    - ☐ on my employer contribution eligibility date

BASIC LIFE / ALTERNATE BASIC LIFE: **Office use: ED** _____

If you elected health coverage, proceed to #17. You must also complete a Beneficiary Designation Form or online at https://sso.tamus.edu/logon.aspx?appid=51.

13. 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 (#13). 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, vision and Long-Term Disability (LTD). If you do not certify that you have other health coverage, you may purchase Basic Life coverage (#14), but you are not eligible for the employer contribution. You may not enroll in both Alternate Basic Life and Optional Life.
14. 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 ☐
15. I wish to enroll in Alternate Basic Life coverage. Yes ☐ No ☐ (If yes, complete a Beneficiary Designation Form. If no, proceed to #17.)
16. I wish to purchase Basic Life coverage. Yes ☐ No ☐ (If yes, complete a Beneficiary Designation Form and proceed to #17. If no, proceed to#17.)

EFFECTIVE DATE OF OPTIONAL COVERAGES:

17. I want the coverages I've selected on the next page to begin:
    - ☐ on my date of hire if I am signing this form on or before my hire date
    - ☐ 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 your 60th day of employment)

Date Stamp

DENTAL: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

To enroll dependents, you must complete a Dependent Enrollment/Change Form/Certification.

18. I wish to enroll in: A&M Dental ☐ Dental HMO ☐

VISION: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

To enroll dependents, you must complete a Dependent Enrollment/Change Form/Certification.

OPTIONAL LIFE: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

You cannot enroll in Optional Life if you have Alternate Basic Life coverage or are covered under Dependent Life by a spouse who works for the A&M System. If enrolling, you must name beneficiaries using a Beneficiary Designation Form or online at https://sso.tamus.edu/logon.aspx?appid=51. Use Single Sign On to get to iBenefits then click on my dependents.

19. I want coverage in this amount times my annual salary:
    ½ ☐ 1 ☐ 2 ☐ 3 ☐ *If you choose ½, 1, 2, or 3 times your annual salary, evidence of good health is not required.*
    4 ☐ 5 ☐ 6 ☐ *If you choose 4, 5 or 6 times your annual salary, you must provide evidence of good health. Until you are approved for the additional coverage, you will be enrolled in 3 times your annual salary.*

DEPENDENT LIFE: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

You cannot enroll your spouse in Dependent Life if he/she has Optional Life or Alternate Basic Life coverage as a System employee. To enroll dependents, complete a Dependent Enrollment Change Form/Certification. You are the primary beneficiary. To name a secondary beneficiary, complete a Beneficiary Designation Form.

20. Plan option: A (based on Optional Life amount) ☐ B (flat rate) ☐ C (based on Alternate Basic Life amount) ☐

ACCIDENTAL DEATH AND DISMEMBERMENT: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

If enrolling, you must name beneficiaries using a Beneficiary Designation Form or online at https://sso.tamus.edu/logon.aspx?appid=51. Use Single Sign On to get to *iBenefits* then click on my dependents.

21. Plan option: Employee coverage ☐ Family coverage ☐ (You do not need to list dependent names.)
22. Coverage amount: $_____ Amounts over $250,000 cannot exceed 10 times salary with a maximum of $800,000.)

LONG-TERM DISABILITY*: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

23. I am eligible to receive half of the employer contribution to apply toward my optional coverages. Because LTD benefits are taxable if the coverage is paid for by the employer , I do ☐ do not ☐ want the employer contribution applied to my LTD 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: ☐ **Enroll** ☐ **Defer/Waive** **Office use: ED** _____

Choose a deduction period for the account(s) in which you are enrolling and list the monthly and annual amounts.
Those with positions through May, June or July may choose only the 9-month deduction option.
If you are enrolling after September 1 of a plan year, your annual total is the 1st of the coming month through August 31 or May 31.

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

	(Sept.–May)	(Sept.–Aug.)	Monthly Amount	Annual Total
24. Health Care Account:	9 months ☐	12 months ☐		
25. Dependent Day Care Account:	9 months ☐	12 months ☐		

26. I ☐ do ☐ do not want my Spending Account reimbursements deposited directly into the same account as my paycheck.
27. 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.

Read the following agreements and sign below.

Payroll Deduction/Pretax Premium/Billing Agreement: I authorize The Texas A&M University System to deduct from my earnings the amount required to cover my share of the premiums for these coverages. As a participant in pretax health/dental/vision/AD&D premiums, I authorize the A&M System to reduce my taxable income by an amount equal to my health/dental/vision/AD&D premiums. If I am being billed, I understand that failure to pay my premium(s) will result in cancellation of coverage.

Waiver Agreement: After my 60-day enrollment period, I understand that in order to enroll in the future I may be required to provide evidence of insurability, and I may enroll in some plans only during enrollment periods and/or be subject to pre-existing condition limitations.

Summer Premiums: If I am budgeted for less than 12 months a year, my summer premiums will be deducted from my May pay. Under certain circumstances, I may choose to be billed for my premiums through the summer. (You will receive additional information in April.)

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