HR 102 (7/20)

System Member:_____

The Texas A&M University System
Open 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*

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:

   Name: _____ UIN_____

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

1. 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) or add Dependents in Workday.

1. I want to enroll in the following health plan: _____
   (Complete a Beneficiary Designation Form for Basic Life, if applicable)
2. I want to cancel my System health coverage. Yes ☐ No ☐
   a. If cancelling, I have other health coverage. Yes ☐ No ☐
   b. If yes, 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 Employees Retirement System or University of Texas System as a current employee or retiree (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

   c. 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.*
3. 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.

1. . I want to enroll in/change to A&M Dental ☐ Dental HMO ☐
2. . 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.

1. . I want to enroll ☐
2. . 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.*

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

Date Stamp

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UIN: ☐☐☐ – ☐☐ – ☐☐☐☐

DEPENDENT LIFE

Office use only: ED _____

You may not enroll your spouse if you have Optional Life or Alternate Basic Life coverage as an employee of The Texas A&M University System.

To add or 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.

1. I want to change to the flat rate Plan B ☐ Spouse ☐ Child ☐
2. I want to cancel all Dependent Life Coverage ☐

ACCIDENTAL DEATH AND DISMEMBERMENT

Office use only: ED _____

1. Plan option: Employee coverage ☐ Family Coverage ☐
2. Coverage amount of: $_____ (Limited to the greater of $250,000 or 10 times your Sept. 1 salary, not to exceed $800,000.) Retiree amounts are limited to $200,000 for those under age 70 and $60,000 for those age 70 and older.
3. I want to cancel my coverage. ☐
4. If you are enrolling in AD&D coverage for the first time, you must also complete a Beneficiary Designation Form.

LONG-TERM DISABILITY*

This is not available to retirees.

Office use only: ED _____

1. I want to enroll in coverage ☐
2. 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 _____

If you work for less than 12 months a year, your annual amount will most likely be deducted over nine months. This is not available to retirees. You must re-enroll in flexible spending accounts every year.

	(Sept.-Aug.)	Monthly Amount	Annual Total
1. Health Care Account	12 months _____	_____	_____
2. Dependent Day Care Account:	12 months _____	_____	_____

Health Care: Annual maximum $2,750. Dependent Day Care: Annual maximum $5,000.

Read the following agreements and sign below.

Payroll Deduction/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. 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.

_____ _____ _____

Signature of employee/retiree in ink (blue preferred) *Daytime phone number* *Signature Date (MM/DD/YYYY)*