Clear Fields Print Form

HR 105 (02/12)

System Member _____

The Texas A&M University System

Benefit Change Form

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

* B C F *

Name _____ _____ _____ ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Last (please print) *First* *MI* *UIN or Social Security number*

Complete items one through four, the sections for the benefits you wish to change, #15 if you are changing anything other than health, and the signature section on page 4.

1. 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 _____ and check here _____ if you are transferring from his/her coverage to your own.

2. Previous name (if applicable) _____

3. New address (if applicable) _____ _____ _____ _____

Street *City* *State* *ZIP*

New phone number (if applicable) (_____) _____

4. You *must* check one of the following to indicate why you are completing this form:
   a. ____ I was hired within the last 60 days. My date of hire was: _____
   b. ____ I am making a change within 45 days after my state contribution eligibility date.
   c. ____ I had a Change in Status less than 60 days ago. (Describe the change from the list below and state the date it occurred.) Change in Status: _____ Date: _____
   d. ____ I wish to cancel and/or decrease Optional Life, Dependent Life, Accidental Death and Dismemberment, and/or Long-Term Disability. Complete the appropriate sections for the coverage(s) you wish to change. Changes will take effect the first of the month following receipt of the form in your Human Resources office.
   e. I have ____ have not ____ used any tobacco products within the past 3 months.

CHANGES IN STATUS

If a dependent becomes ineligible for coverage, only that dependent may be dropped. However, if a new dependent is added to medical, dental, vision or dependent life coverage, other existing dependents can be added to the coverage without having to provide evidence of good health. In general, changes will be effective the first of the month following receipt of this form in your Human Resources office. When adding dependents, you may have a choice of effective dates, as described on the Dependent Enrollment/ Change Form. Contact your Human Resources office for more information. The following are Changes in Status:

- Employee's marriage or divorce or death of employee's spouse
- Birth, adoption or death of a dependent child
- Change in employee's, spouse's or dependent child's employment status that affects benefit eligibility, such as leave without pay, benefit eligibility with current employer
- Child becoming ineligible for coverage due to reaching maximum age or marrying (dependent children enrolled in health coverage may be married)
- Changes in the employee's, spouse's or a dependent child's residence that would affect eligibility for coverage
- Employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child
- Changes made by a spouse or dependent child during his/her annual benefit/insurance enrollment period with another employer
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid
- Significant employer- or carrier-initiated changes in or cancellation of the employee's, spouse's or dependent child's coverage
- Change in day care costs due to a change in provider, change in provider's fees (if the provider is not a relative) or change in the number of hours the child needs day care (for Dependent Day Care Spending Accounts)
- The employee or dependent child loses coverage under the state Medicaid or child health plan or becomes eligible for premium assistance under the Medicaid or child health plan.

Office use: ED _____

Date Stamp

Office use only

HEALTH

Office use: ED_____

- You may enroll in coverage, cancel coverage or add/drop dependents during your initial 60-day enrollment period, during Annual Enrollment or within 60 days of experiencing a Change in Status (see first page of form). If you wish to make your health coverage effective before your employer contribution eligibility date, you will pay the full premium until you begin receiving the employer contribution. ***Please allow 7 business days processing time to carrier before scheduling appointments or receiving prescriptions.***
- You may change health plans during your initial 60-day enrollment period, during Annual Enrollment or if you are moving out of your HMO's service area.

PRETAX PREMIUMS

5. Your health/dental/vision/AD&D premiums will automatically be deducted from your pay before taxes unless you are covering non-qualifying dependents. This will increase your take-home pay. To waive this option and pay these premiums after taxes, check here: ____
6. I am adding coverage for myself _____. (To add dependent coverage, complete a Dependent Enrollment/Change Form.)
7. I wish to enroll in the following carrier _____
8. I understand that A&M Care health care coverage begins on my state contribution eligibility date. If my Human Resources office receives this form during my initial 60-day enrollment period, I want my chosen coverage to begin:
   _____ on the first of the month after the day on which my Human Resources office receives this form
   _____ on my employer contribution eligibility date
9. I am cancelling coverage for myself (if you have any covered dependents, their coverage will also be cancelled.) _____
   To cancel coverage for dependents only, complete a Dependent Enrollment/Change Form.

BASIC LIFE / ALTERNATE BASIC LIFE

Office use: ED_____

If you elected health coverage, proceed to #15. You must also complete a Beneficiary Designation Form.
If you cancelled your health coverage, proceed to #10.

10. 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 (#12). On your employer contribution eligibility date, up to 1/2 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 (#13, but you are not eligible for the employer contribution. You may not enroll in both Alternate Basic Life and Optional Life.
11. I have other health insurance through (pick one of the following):
    An A&M system-offered health 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 former dependent _____
    Another company, affiliation plan or Medicare, Medicaid or other government-offered plan _____
12. I wish to enroll in Alternate Basic Life coverage. Yes ____ No ____ (If yes, complete a Beneficiary Designation Form. If no, proceed to #15.)
13. I wish to purchase Basic Life coverage. Yes ____ No ____ (If yes, complete a Beneficiary Designation Form and proceed to #15.)
14. I wish to cancel my Basic/Alternate Basic Life coverage _____.

EFFECTIVE DATE OF OPTIONAL COVERAGES:

15. If my Human Resources office receives this form during my initial 60-day enrollment period, I want the coverages I've selected on this Change form to begin:
    _____ on the first of the month after the day on which my Human Resources office receives this form
    _____ on my employer contribution eligibility date

DENTAL

Office use: ED_____

- You may enroll/cancel and add/drop dependents during your initial 60-day enrollment period, during Annual Enrollment or within 60 days of experiencing a Change in Status (see first page of form).

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16. I wish to enroll in: A&M Dental _____ Dental HMO _____
17. I am adding coverage for myself _____ To add dependent coverage, complete a Dependent Enrollment/Change Form.
18. I am cancelling coverage for myself (if you have any covered dependents, their coverage will also be cancelled) _____
    To cancel coverage for dependents only, complete a Dependent Enrollment/Change Form.

VISION

Office use: ED_____

- You may enroll or cancel coverage during your 60-day enrollment period during Annual Enrollment.
- You may add/drop dependents during your 60-day enrollment period, during Annual Enrollment or within 60 days or experiencing a Change in Status (see first page of form.)

19. I am adding coverage for myself _____. To add dependent coverage, complete a Dependent Enrollment/Change Form.
20. I am cancelling coverage for myself (if you have any covered dependents, their coverage will also be cancelled) _____. To cancel coverage for dependents only, complete a Dependent Enrollment/Change Form.

OPTIONAL LIFE

Office use: ED_____

- To add coverage after your initial 60-day enrollment period, increase coverage, or enroll in the four, five or six times salary option, you must complete a Minnesota Life Evidence of Insurability Form, available from your Human Resources office or online at www.tamus.edu/assets/files/benefits/pdf/EOI2010.pdf. However, if you have a Change in Status (see first page of form), you may enroll in half or one times salary or increase coverage one increment to three times salary within 60 days of the event without providing evidence of insurability. You may cancel coverage at any time.
- You may not enroll in Optional Life if you have Alternate Basic Life coverage or are covered under Dependent Life by a spouse who works for The Texas A&M University System.
- If enrolling, you must name beneficiaries using a Beneficiary Designation Form or by going to https://sso.tamus.edu/logon.aspx?appid=51. and clicking on My Beneficiaries.

21. I want the following coverage amount: ½_____ 1_____ 2_____ 3_____ times my annualized salary.
22. I have _____ have not _____ used tobacco products within the past 3 months.
23. If I have had a decrease in my percent effort (for example, from full-time to 75%), I would like to:
    _____keep my original amount of coverage
    _____adjust my coverage amount to match my salary
24. I want to decrease or cancel coverage: Cancel_____ Decrease to 1/2_____ 1_____ 2_____ 3_____ 4_____ 5_____

DEPENDENT LIFE

- After your initial 60-day enrollment period, you must complete additional forms (available from your Human Resources office or online at tamus.edu/benefits/publications/#insurance) to apply for coverage unless you have had a Change in Status (see first page of form).
- To add or cancel coverage on dependents, you must complete a Dependent Enrollment/Change Form (available from your Human Resources office or online at tamus.edu/benefits).
- You may not enroll your spouse in Dependent Life if your spouse has Optional Life or Alternate Basic Life coverage as an employee of the A&M System.
- Under this coverage, you are the primary beneficiary. To name a secondary beneficiary, complete a Beneficiary Designation Form.

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

Office use: ED_____

- You may enroll in or change your coverage during your initial 60-day enrollment period or during Annual Enrollment.
- You may change from employee-only to family coverage and vice versa during your 60-day enrollment period, during Annual Enrollment or within 60 days of experiencing a Change in Status (see first page of form).
- You may decrease or cancel coverage at any time.
- If you choose family coverage, all eligible dependents will be covered automatically.
- If enrolling, you must name beneficiaries using a Beneficiary Designation Form: https://sso.tamus.edu/logon.aspx?appid=51 and clicking on My Beneficiaries.

25. I want employee-only coverage _____ family coverage _____
26. I want coverage in the amount of $_____0,000 (Amounts over $250,000 cannot exceed 10 times salary, to a maximum of $800,000.)
27. 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*

Office use: ED_____

- You may enroll during your initial 60-day enrollment period, during Annual Enrollment, or within 60 days of a Change in Status (see first page of form).
- You may cancel coverage at any time.

*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.

28. I want to enroll in coverage _____.
29. I am eligible to receive half of my 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.
30. If I have had a decrease in my percent effort (for example, from full-time to 75%), I would like to:
    _____keep my original amount of coverage
    _____adjust my coverage amount to match my salary
31. I have ____ have not ____ used tobacco products within the past 3 months.
32. I want to cancel my coverage _____.

FLEXIBLE SPENDING ACCOUNTS **Office use: ED**

You may enroll, change deduction amounts or cancel enrollment during your 60-day enrollment period or within 60 days of experiencing a Change in Status (see first page of form). If you are currently participating in a Flexible Spending Account and you wish to continue participating during the next plan year, you must re-enroll during Annual Enrollment.

Health Care: Monthly minimum–$20; annual maximum–$4,800. Dependent Day Care: Monthly minimum–$40; annual maximum–$5,000 ($2,500 maximum if married and filing separate income tax return).

33. I am enrolling in an account(s). (Those with positions through May, June or July may choose only a 9-month deduction period.) If you are enrolling after September 1 of a plan year, your annual total is the first of the coming month through August 31 or May 31.

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

34. I am changing my deduction amount. Going forward, my new deduction amount will be _____ per month for Health Care and/or _____ per month for Dependent Day Care.
35. I want to stop contributions to my Health Care Account _____ Dependent Day Care Account _____.
36. If enrolling in a Health Care Account, I would like a debit card _____ .
37. I do____ do not____ want my Spending Account reimbursements deposited directly into the same account as my paycheck.

After completing your changes, read and sign the agreements 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. If I elect to participate 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.

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, I may enroll in some plans only during specified enrollment periods and/or be subject to pre-existing condition limitations.

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.

Summer Premiums: If I am budgeted for less than 12 months a year, I understand that my summer premiums will be deducted from my May pay. If my monthly premiums are more than $20, I understand that I may choose to be billed for my premiums through the summer.

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.

_____ _____ ☐☐ ☐☐ ☐☐☐☐

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