

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.



1. Name _____ 2.

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

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 Social Security number/UIN _____ 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 "defaults" become #9 participate in pre-tax and #10 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. If you wish to waive this option and pay these premiums after taxes, check here: _____

10. I have ___ have not ___ used any tobacco products within the past 12 months.

HEALTH: **Enroll** **Waive (see #9)** **Office use: ED** _____

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

You are automatically enrolled in A&M Care 350 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 350 ___ 1250 ___ OR the following health plan _____

12. I understand that A&M Care 350 coverage automatically begins on my employer contribution eligibility date unless I waive coverage or select a different coverage. I want my A&M Care 350 or other chosen coverage 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

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

If you elected health coverage, proceed to #17. You must also complete a Beneficiary Designation Form. If you waived health coverage, proceed to #13.

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 91st day of employment)

Date Stamp

If you enroll in Long-Term Care through John Hancock, your coverage will become effective the first of the month following enrollment.

HR 100 (New Employee Benefit Enrollment Form)

DENTAL: [] Enroll [] Defer/Waive

Office use: ED _____

To enroll dependents, you must complete a Dependent Enrollment 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 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.

19. I want coverage in this amount times my annual salary:

1/2 ___ 1 ___ 2 ___ 3 ___ If you choose 1/2, 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 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.

21. Plan option: Employee coverage ___ Family coverage ___ (You do not need to list dependent names.)

22. Coverage amount: \$ ___ 0,000 (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.

LONG-TERM CARE:

To enroll in Long-Term Care, you will need to use separate forms, available through your Human Resources office or from John Hancock (800) 498-9100, or you can enroll online at http://tamus.JHancock.com (username=TAMUS; password=benefit)

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-\$4,800.

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

Table with 4 columns: Account Type, Period (Sept.-May / Sept.-Aug.), Monthly Amount, Annual Total. Rows for Health Care Account and Dependent Day Care Account.

26. ___ I want my Spending Account reimbursements deposited directly into the same account as my paycheck.

27. If enrolling in a Health Care Account, I would like a 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. 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.

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 informati

Signature of employee in ink (blue preferred)

Daytime phone number

Signature date

Signature date grid: [][] - [][] - [][][][]