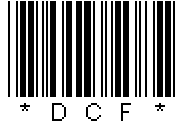
HR 101 (10/09)

System Member ____
Documents
reviewed _____

The Texas A&M University System

Dependent Enrollment/Change Form/Certification

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



Section I

Employee/Retiree name (please print) ________________________________ *Last* *First* *MI* | ___ ___ ___ – ___ ___ – ___ ___ ___ ___ *Social Security number or UIN*

If you have a spouse/parent/child who currently works for The Texas A&M University System, please provide his/her name ______________________________ and Social Security number/UIN ____________________.

Section II Office use: ED ___________

List the required information for each dependent you wish to add to or drop from coverages. Write **"Add"** or **"Drop"** under the coverage column for each dependent. Write **"Same"** if you are retiring and continuing your current dependent coverage. To enroll eligible dependents in Long-Term Care, contact John Hancock directly at (800) 498-9100 or http://tamus.jhancock.com/ (username = TAMUS; password in all lowercase = mybenefit) instead of using this form. **Adding/dropping a dependent because of a Change in Status must be done within 60 days after the change.** In the Qualifying Dependent column, put "Y" if your child meets any of the criteria below and qualifies for premiums to be deducted on a pre-tax basis, or "N" if he/she does not:

1. Will be 18 or younger on 12/31/09.
2. Will be older than 18 but younger than 24 on 12/31/09, is a full-time student and provides less than half of his/her own financial support.
3. Will be older than 18 on 12/31/2009, is not necessarily a full-time student, but receives more than half of his/her financial support from you.

Dependent Name (last, first, MI)	Qual. Dep.	Relationship and gender (see Section V)	Birthdate (mm/dd/yyyy)	Ending date of relationship #6, 7, 8 (see back)	Health	Dental	Vision	Depend. Life†
Example: *Doe, John P.*	*Y*	*8/M*	*01/01/1998*	*01/01/2016*	*Add*	*Add*	*Add*	

† If you are adding dependents to Dependent Life, choose one of the following plans:

Plan A _____ Spouse amount: $25,000 _____ $50,000 _____ $75,000 _____ $100,000 _____ $150,000 _____ $200,000 _____
Child amount: Same as current child coverage _____ OR $10,000 _____

Plan B (flat rate) _____, Plan C (based on Alternate Basic Life coverage) _____ **If you and your spouse are both employed by or retired from the A&M System, you cannot both cover the same child(ren) under Health, Dental, Vision and/or Dependent Life.**

If you are adding dependents at a time other than during Annual Enrollment, you must complete Section IV of this form.
If you are adding dependents by providing evidence of good health, coverage is effective the first of the month following approval.
If you are continuing dependent coverages due to retirement, check here_____ and skip Sections III and IV.
If any of these dependents are transferring coverage from another A&M System employee, please indicate the other employee's name ________________________ and Social Security number/UIN ____________________.

Section III If you are adding or dropping a dependent(s) to or from health/dental/vision coverage, you must complete A, B, C or D.

A. I was hired within the last 60 days. yes____ no____ Date of hire: ________________
B. I am making a change within 45 days after my employer contribution eligibility date. yes____ no____
C. I am adding/dropping a dependent during the Annual Enrollment period. yes____ no____
D. Write the **date** of the Change in Status you experienced on the line next to the appropriate event:
   - 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 or spouse taking a job with a new employer ___________
   - Child becoming ineligible for coverage due to reaching age 25 or marrying ___________
   - 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 ___________

Date Stamp

Section IV If you are dropping an eligible dependent from your existing coverage, the effective date is the end of the month in which your Human Resources office receives the paperwork to drop the dependent. However, if a dependent becomes ineligible for coverage, his/her coverage ends at the end of the month in which he/she becomes ineligible, regardless of when your Human Resources office receives the paperwork.

If you are completing this form on or before your hire date, choose the date on which your dependent's coverage will take effect:

Medical
___ Your hire date
___ 1st of the month following receipt of form in the HR office
___ Your employer contribution eligibility date

Optional
___ Your hire date
___ 1st of the month following receipt of form in the HR office
___ Your employer contribution eligibility date

If you are adding a dependent to your coverage after your hire date but within 60 days of employment/eligibility, choose an effective date:

Medical
___ 1st of the month following receipt of form in the HR office
___ Your employer contribution eligibility date

Optional
___ 1st of the month following receipt of form in the HR office
___ Your employer contribution eligibility date

If you are adding a dependent within 60 days of a Change in Status, choose an effective date:

___ The date of the Change in Status. However, if this form is received in the Human Resources office after the Change in Status, the change will be effective the first of the month, after the receipt of the form (If the form is received the first day of the month, coverage can be effective on that day.) If you choose this option, you must pay premiums for the entire month.*

___ 1st of the month following receipt of this form in the HR office

* Newborn coverage, if added through this form within 60 days of birth, is effective on the birthdate.

Section V This document serves as an affidavit that the dependent(s) you are adding to your Texas A&M University System benefit plan(s) meets the legal definitions of the eligible relationships described below. A dependent is a spouse or an unmarried child younger than age 25. *For relationships 6, 7 and 8 (below): If no ending date for the relationship is specified in the legal document, coverage will end on the child's 19th birthday.* Coverage also is available for physically or mentally disabled dependent children if the disability occurred before age 25.

Spouse: If I am adding my spouse to my coverage, I certify that our relationship meets one of the following definitions:

1. I have a valid marriage license that complies with the requirements of the Texas Family Code, or my spouse is a common-law spouse as defined in the Texas Family Code, which states: There are three essential elements of a common-law marriage: 1) an agreement presently to become husband and wife, 2) a living together pursuant to the agreement and cohabitation as husband and wife and 3) a holding out of each other to the public as husband and wife.

Child: If I am adding a child to my coverage, I certify that our relationship meets one of the following definitions:

2. Natural or Previously Adopted Child: I have a birth certificate for my child showing me to be his/her parent, or I have previously adopted the child.
3. Stepchild: I am in a "parent-child relationship" with the child. I understand that my stepchild is eligible for coverage whether or not he/she lives in my home.

For the following relationships, documentation is required:

4. Adopting a Child or Prospective Adopted Child: The child has been legally placed in my care by an authorized agency or placed in my home for the required "probationary period" before final adoption through an authorized agency, *or* I have received documents giving me temporary legal custody (documentation of legal custody is required). Authorized agency means a public social agency authorized to care for children or to place children for adoption, or a private association, corporation or person approved for that purpose by the Texas Department of Human Services through a license, certification or other means. (Texas Family Code, Parent-Child Relationship, Title 2, Chapter, 11.01, Section 7)
5. Grandchild: My grandchild is living in my household. Documentation required: proof of residency (school records, a federal or state benefit program, a court record or Texas driver's license). *Recertification will be required annually.*
6. Foster Child: The child was placed in my home by a licensed placement agency. Documentation required: placement document.
7. Legal Guardian: I am the person who, under court order, is the guardian of the child. (Texas Family Code, General Provisions, Chapter 51.02, Section 3) Documentation required: court order.
8. Managing Conservator: My relationship with the child is one of managing conservator appointed by court order. (Texas Family Code, Section 101.019) Documentation required: court order.

Certification and signature: I certify that I have read the legal definitions of the relationships that I am claiming in order to add/drop my dependent(s). I understand that I may be required to provide additional documentation. I further understand that should it be found that I have made a false statement in connection with my relationship to such dependent(s), my benefit coverage will be canceled and I may be prosecuted to the full extent of the law.

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.

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.

Employee/Retiree signature in ink (blue preferred): ____________________

____
Daytime phone number

[|] - [|] - [| | |]
Signature date (MM/DD/YYYY)