

Section A: Employee Information

Employee Name (last name, first name, middle initial)		Gender	Birth date	Social Security Number		Annual Salary
Street Address	City	State	Zip	Home Phone	Department	Work Phone

New Employee or Status Change Full Time or Part Time Employment or Status Change Date: _____

Section B: Basic Coverage

I WANT TO KEEP the Basic Coverage: UT Select Medical Insurance (Employee Only) / Term Life Insurance (\$10,000 coverage) * Accidental Death & Dismemberment
STOP HERE for Basic Coverage only. Complete and sign the attached Life/Accidental Death and Dismemberment beneficiary designation form.

Section C: Selective Medical Insurance

Medical Plan and Coverage

Employee Only Employee and Child(ren)
 Employee and Spouse Employee and Family

I DO NOT want Medical Insurance

Effective Date _____ Premium _____

Waive Medical Coverage

I wish to WAIVE Medical Coverage
 and use premium sharing dollars towards other qualified insurance coverages. I am enrolled in a health plan that is not provided by the State of Texas.

Section D: Selective Dental Insurance

Dental Plan and Coverage

UT Delta Dental Select Assurant DMO
 Employee Only Employee and Spouse
 Employee and Child(ren) Employee and Family

I DO NOT want Dental Insurance

Effective Date _____ Premium _____

Section E: Vision Insurance

Employee Only Employee and Child(ren) Employee and Spouse Employee and Family
 I DO NOT want Vision Insurance.

Effective Date _____ Premium _____

Section F: Accidental Death & Dismemberment (AD&D)

\$10,000 Basic Coverage is automatic when enrolled in UT medical plan.
 Employee Options:

Voluntary amount of \$ _____
 (All amounts must be in \$10,000 increments)
 Maximum 10x annual salary \$ _____

I DO NOT want additional AD/D insurance

Effective Date _____ Premium _____

Section G: Term Life Insurance

\$10,000 Basic Coverage is automatic when enrolled in UT medical plan.
 Employee Options:

1 x Annual Earnings 4 x Annual Earnings*
 2 x Annual Earnings 5 x Annual Earnings*
 3 x Annual Earnings 6 x Annual Earnings*
 *Requires EO

I DO NOT want additional Life insurance

Effective Date _____ Premium _____ Pretax _____ After tax _____
 Effective Date _____ Premium _____ Pretax _____ After tax _____

Dependent Options: \$10,000 Child/Spouse (requires at least \$20,000 voluntary employee coverage)
 Voluntary amount of \$ _____ for spouse (not to exceed 50% of employee coverage)

I DO NOT want additional AD/D insurance for my dependent(s)

Effective Date _____ Premium _____

Dependent Options: \$10,000 Child/Spouse (Requires at least 1 x annual salary employee coverage) \$15,000 Spouse*
 \$40,000 Spouse*
 *Requires EO

I DO NOT want additional Life insurance for my dependent(s)

Effective Date _____ After Tax Premium _____

Section H: Short Term Disability Insurance (STD) I DO NOT want Short Term Disability Insurance. (Maximum monthly benefit of \$5,000)
 I DO want Short Term Disability Insurance. Effective Date _____ Premium _____

Section I: Long Term Disability Insurance (LTD) I DO NOT want Long Term Disability Insurance.
 I DO want Long Term Disability Insurance. Effective Date _____ Premium _____

Section J: Long Term Care

I understand I must enroll within 31 days of eligibility as a new employee directly with the company for Long Term Care (LTC) if I am interested in the policy without proving insurability.

Signature _____ Date _____

Section K: Authorization

I hereby request my employer to arrange for the issuance of the insurance for which I am eligible for and authorize my employer to make the proper premium deductions for my earnings and my contributions toward the cost of these benefits. I acknowledge I have received information about and am eligible for continuation of coverage (COBRA). My signature below indicates that I have read and understand this form and the corresponding instructions, as well as any material provided to me. I understand that no refund of premium can be made for failure to notify the Benefits Office of a drop in coverage due to a change in dependent status. ANY SECTION LEFT BLANK INDICATES THAT I DID NOT SELECT THE COVERAGE.

Employee Signature _____ Date _____
 Approved by _____ Date _____