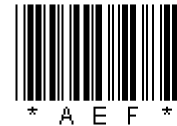
HR 102 (7/09)

System Member:________

The Texas A&M University System

Annual 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. [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]
   Last (please print) *First* *MI* *Social Security number or 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, please provide his/her name ____________________________ and Social Security number/UIN ________________________

PRETAX PREMIUMS **Office use only: ED __________**

5. I want health/dental/vision/AD&D premiums for myself and qualifying dependents to be deducted from my pay before taxes. YES____ NO____
6. I have ____ have not ____ used tobacco products within the last 12 months.

HEALTH **Office use only: ED __________**

To add or drop dependents, you must complete a Dependent Enrollment Form/Certification.

7. I want to enroll in the following health plan: ________________________________ (Complete a Beneficiary Designation Form for Basic Life (if applicable.)
8. I want to cancel my System health coverage 8.
9. If cancelling, I have other health coverage. YES ____ NO ____ (If no, go to question #11.)
10. If yes, I have other health insurance through (pick one of the following, then skip question #11):
    - 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 former employee ______ (if yes, skip to #14.
    - A state-provided plan such as the Employees Retirement System or University of Texas System as a dependent _______
    - Another company, affliliation plan or Medicare, Medicaid or other government-offered plan ______
11. I want to keep Basic Life coverage, but I understand that I must pay for this coverage myself. YES ______ NO ______ (Proceed to the next section in which you wish to make changes on this form.)
12. I want to enroll in Alternate Basic Life. YES ______ NO ______ (If you answer yes, complete #13.) You must also complete a Beneficiary Designation Form. *If you currently have no life insurance or only $5,000 in coverage, you will need to provide evidence of good health to increase coverage to $50,000.*
13. 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 Form/Certification.

14. I want to enroll in/change to A&M Dental ______ Dental HMO ______
15. 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 Form/Certification.

16. I want to enroll ______ 17. 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.*

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

Date Stamp

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DEPENDENT LIFE **Office use only: ED __________**

You may not enroll your spouse if your spouse has Optional Life or Alternate Basic Life coverage as an employee of The Texas A&M University System. To drop dependents (unless you're cancelling all coverage), you must complete a Dependent Enrollment Form/ Certification. To enroll dependents or switch from Dependent Life Plan B to Plans A or C, you must provide evidence of good health.

21. I want to change to the flat rate Plan B. ______
22. I want to cancel all Dependent Life coverage. ______

ACCIDENTAL DEATH AND DISMEMBERMENT **Office use only: ED __________**

23. Plan option: Employee coverage ______ Family coverage _______
24. Coverage amount of: $_____0,000. (Limited to the greater of $250,000 or 10 times your Sept. 1, 2008. salary, not to exceed $800,000.)
25. I want to cancel my coverage. ______
26. I am enrolling in AD&D coverage for the first time, and I have designated the following beneficiaries (attach an additional sheet if necessary):

Primary Beneficiary(ies)

Name	*Relationship*	*Distribution by %*	*Address (Street/P.O. Box, City, State, ZIP)*

Secondary Beneficiary(ies)

Name	*Relationship*	*Distribution by %*	*Address (Street/P.O. Box, City, State, ZIP)*

LONG-TERM DISABILITY **Office use only: ED __________**

27. I want to enroll in coverage. ______
28. I have ____ have not ____ used tobacco products within the last 12 months.
29. I want to cancel my coverage. ______

LONG-TERM CARE

Evidence of good health is required for all enrollments or increases.

To enroll yourself or your spouse or to increae your coverage or your spouse's coverage or to have information sent to eligible dependents, obtain a John Hancock packet from your Human Resources office or contact John Hancock at (800)498-9100 or http://tamus.jhancock.com (username=TAMUS, password=mybenefit).

FLEXIBLE SPENDING ACCOUNTS **Office use only: ED __________**

If you work for less than 12 months a year, you can enroll only in the nine-month option.

	(Sept.-May)	(Sept.-Aug.)	Monthly Amount	Annual Total
30. Health Care Account	9 months _____	12 months _____	__________	___________
31. Dependent Day Care Account:	9 months _____	12 months _____	__________	___________

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).

32. If enrolling in a Health Care Account, I would like a debit card ______
33. I want my Spending Account reimbursements to be deposited into the same account as my paycheck. ______
34. I want to cancel my: Health Care Account _______ Dependent Day Care Account ______

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.

If you are designating beneficiaries, this form must be witnessed. The date of the witness' signature must be the same as yours. The witness cannot be a beneficiary or your relative.

________________________________ ________________________________ ______________

Signature of witness in ink (blue preferred) *Witness's name (printed)* *Date*

________________________________ ____________________ [|] – [|] – [| | |]

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