

HR 107 (8/08)

System Member _____

Check one:

___ TRS

___ ORP

The Texas A&M University System
Retiree 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 Last (please print) First MI

2. Social Security number or UIN

3. Retirement date Month Day Year 4. Birthdate Month Day Year

5. Phone number 6. Home e-mail address

7. Address State ZIP

8. If you have a spouse who is an employee or retiree of The Texas A&M University System, please provide his/her name and Social Security number or UIN.

Some of your benefits will change upon retirement. To continue dependent coverage, you must complete a new Dependent Enrollment Form/Certification (HR 101). You must also rename life insurance beneficiaries using a Beneficiary Designation Form (HR 103).

HEALTH

Office use: ED

- If you are 65 or older and will not continue working for The Texas A&M University System, Medicare will become your primary payer for your insurance...
You are eligible for the A&M Care 65 Plus plan if you are retired and you and any covered dependents are disabled or 65 or older and enrolled in Parts A and B of Medicare.

- 9. I wish to remain enrolled in my current coverage (please state name of plan):
10. I am moving out of my HMO's service area. I wish to change to
11. I am enrolled in an A&M Care plan and wish to change to: A&M Care 65 PLUS A&M Care 350 A&M Care 1250
12. I am currently not enrolled in health coverage or I am a former A&M System employee returning to retire with the System and I wish to enroll in the following health plan:
13. I am a former employee, and I want my chosen coverage to begin:
the first of the month after the day on which my Human Resources office or Employee Service Center receives this form
on my employer contribution eligibility date (first of the month following the 91st day after you apply for benefits)
14. I do not want coverage/I wish to cancel coverage. (If so, proceed to #15. Otherwise, proceed to #20.)

BASIC LIFE/ALTERNATE BASIC LIFE

Office use: ED

If you are enrolled in a System health plan, or if you are not enrolled but have Basic Life or Alternate Basic Life, your Basic Life/Alternate Basic Life coverage will continue automatically and remain the same. In this case, you do not need to complete this section.

- 15. 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 (#17). 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 (#17), but you are not eligible for the employer contribution. You may not enroll in both Alternate Basic Life and Optional Life.
16. 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
17. I wish to enroll in Alternate Basic Life coverage. Yes No (If yes, complete a Beneficiary Designation Form and proceed to #20. If no, proceed to #20.)
18. I wish to purchase Basic Life coverage. Yes No (If yes, complete a Beneficiary Designation Form.)
19. I wish to cancel my Basic/Alternate Basic Life coverage.

EFFECTIVE DATE OF OPTIONAL COVERAGES (FOR FORMER EMPLOYEES ONLY):

- 20. I want the coverages I've selected on page 2 to begin:
the first of the month after the day on which my Human Resources office or Employee Service Center receives this form
on my employer contribution eligibility date (first of the month following the 91st day after you apply for benefits)

Date Stamp

DENTAL

Office use: ED _____

- 21. I wish to remain enrolled in my current coverage, which is:
A&M Dental ___ Dental HMO ___.
22. I wish to change to A&M Dental ___ Dental HMO ___.
23 I am a former A&M System employee returning to retire with the A&M System and I wish to enroll in
A&M Dental ___ Dental HMO ___.
24. I wish to cancel my A&M Dental or Dental HMO coverage _____.

VISION

Office use: ED _____

- 25. I am currently enrolled and wish to keep my coverage as is _____.
26. I am a former A&M System employee returning to retire with the A&M System and I wish to enroll _____.
27. I wish to cancel my coverage _____.

OPTIONAL LIFE

Office use: ED _____

If you are younger than age 70, the maximum coverage amount is \$100,000 or your current coverage level, whichever is less. If you are age 70 or older, your maximum coverage level is \$60,000. If you are not enrolled, you may do so by completing a Fort Dearborn Evidence of Insurability Form. If enrolled, you must complete a new Beneficiary Designation Form.

- 28. Based on the limitation above, I want _____ of coverage.
29. I have ___ have not ___ used tobacco products within the past 12 months.
30. I wish to cancel coverage _____. In addition, I certify that I do not have A&M System health coverage, but I do have other health coverage.
Please move my current Optional Life coverage amount (up to \$50,000) to Alternate Basic Life so it will be paid for by the employer contribution.
Yes ___ No ___

DEPENDENT LIFE

Office use: ED _____

If you have Plan A, the coverage amount will change to reflect 1/2 of your new Optional Life amount. If you have Plan B, the coverage amount will remain \$5,000 for each covered dependent. If you have Plan C, your coverage won't change. Under this coverage, you are the primary beneficiary. To name a secondary beneficiary, complete a Beneficiary Designation Form.

- 31. I wish to stay enrolled in the same plan, although I understand the coverage amount may decrease _____.
32. I wish to change from Plan A or C to Plan B _____. (You must provide evidence of insurability to enroll or to move from Plan B to Plan A or C.)
33. I wish to cancel coverage _____.

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

Office use: ED _____

If you are younger than 70, your maximum coverage amount is \$200,000. If you are age 70 or older, your maximum coverage amount is \$60,000. In addition, your premium will automatically increase when you retire. If enrolled, you must complete a new Beneficiary Designation Form.

- 34. I want coverage in the amount of \$___0,000.
35. I want individual ___ family ___ coverage.
36. 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 You are no longer eligible for this plan.

LONG-TERM CARE

If you are enrolled in this plan, you will receive information from John Hancock, the carrier, about continuing your coverage. To continue, you must select a premium payment option of monthly, quarterly, semi-annually or annually. You will be billed directly by John Hancock. To enroll, ask your Human Resources office or Employee Service Center for a Long-Term Care packet or contact John Hancock at (800) 498-9100.

After completing your changes, read the following agreements and sign below.

Billing Agreement: I authorize The Texas A&M University System to bill me or draft my bank account to cover my share of the premiums for these coverages. I understand that failure to pay my premium(s) will result in cancellation.

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 insurability 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. Benefits will be paid based on coverage records in my insurance file and in accordance with the terms of the applicable group policy.

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 retiree in ink (blue preferred)

Daytime phone number

Signature date (MM-DD-YYYY) grid

Signature date (MM-DD-YYYY)