NAME (Last, First, MI)
Address, City, State, Zip Code

SECTION B: WAIVE/DECLINE MEDICAL COVERAGE
☐ No Tobacco Users
☐ Subscriber
☐ Spouse
☐ Child(ren)

SECTION C: MEDICAL COVERAGE

 UT SELECT BCBS PPO
Eff. Date __________
☐ Emp. Only
☐ Emp. Spouse
☐ Emp. + Child(ren)
☐ Emp. + Family

 Declare Tobacco User

 $30 Per Person $90 Maximum Per Family

 SECTION D: DENTAL COVERAGE

 UT DELTA DENTAL PPO
Eff. Date __________
☐ Emp. Only
☐ Emp. Spouse
☐ Emp. + Child(ren)
☐ Emp. + Family

 UT DELTA DENTAL PLUS
Eff. Date __________
☐ Emp. Only
☐ Emp. + Spouse
☐ Emp. + Child(ren)
☐ Emp. + Family

 UT DELTA DENTAL HMO
Eff. Date __________
☐ Emp. Only
☐ Emp. + Spouse
☐ Emp. + child(ren)
☐ Emp. + Family

 SECTION E: VISION COVERAGE

 SUPERIOR VISION
Eff. Date __________
☐ Emp. Only
☐ Emp. + Spouse
☐ Emp. + Child(ren)
☐ Emp. + Family

 SUPERIOR VISION PLUS
Eff. Date __________
☐ Emp. Only
☐ Emp. + Spouse
☐ Emp. + Child(ren)
☐ Emp. + Family

 SECTION F: VOLUNTARY DISABILITY COVERAGE

 SHORT TERM DISABILITY
Eff. Date __________
☐ Elect Coverage
☐ Decline

 LONG TERM DISABILITY
*eligibility based on appointment
Eff. Date __________
☐ 90 day elim w/COLA
☐ 180 day elim w/COLA
☐ Decline

 ☐ 90 day elim w/out COLA
☐ 180 day elim w/out COLA

 SECTION G: VOLUNTARY GROUP TERM LIFE COVERAGE

 Employee:
 ☐ 1x Salary
 ☐ 2x Salary
 ☐ 3x Salary
 ☐ 4x Salary
 ☐ 5x Salary
 ☐ 6x Salary
 ☐ 7x Salary
 ☐ 8x Salary
 ☐ 9x Salary
 ☐ 10x Salary
 EOI is required when new employees enroll in 4-10x salary.

 ☐ Decline
 Eff. Date __________

 Spouse and eligible dependent child requires at least 1x salary employee coverage
 ☐ $10,000 for spouse and child/ren
 ☐ $25,000 spouse & $10,000 child/ren ( EOI required)
 ☐ $50,000 spouse & $10,000 child/ren ( EOI required)

 ☐ Decline
 Eff. Date __________
**Accidental Death and Dismemberment**

<table>
<thead>
<tr>
<th>Employee Options:</th>
<th>Spouse Options:</th>
<th>Child(ren) Options:</th>
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</thead>
<tbody>
<tr>
<td>☐ Maximum of 10 times annual salary, not to exceed $2,000,000</td>
<td>☐ 50% of employee’s amount</td>
<td>☐ $10,000 per each eligible dependent child. (requires at least $20,000 voluntary employee coverage)</td>
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<tr>
<td>☐ Fixed amount $__________ ($10,000 increments up to 10 times employee salary or $2,000,000 whichever is less)</td>
<td>☐ Fixed Amount $__________(10,000 increments up to 50% the amount selected as voluntary employee coverage)</td>
<td>☐ Decline</td>
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**SECTION H: UT FLEX MEDICAL EXPENSE REIMBURSEMENT ACCOUNT AND / OR UT FLEX DAYCARE REIMBURSEMENT ACCOUNT**

<table>
<thead>
<tr>
<th>Daycare Reimbursement Account</th>
<th>Eff. Date</th>
<th>$___________ per month</th>
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<tbody>
<tr>
<td>Medical Expense Reimbursement Account</td>
<td>Eff. Date</td>
<td>$___________ per month</td>
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The calendar year maximum election is $5,000. Your monthly deductions will be made based on number of paychecks the employee will receive during the Plan Year. Monthly Deductions are between $15.00 and $416.66 per month.

**SECTION I: DEPENDENT ENROLLMENT or CANCELLATION**

Notice about Social Security Numbers (SSN): Federal law requires The University of Texas System (System) to report income and the SSN for all employees to whom compensation is paid. Employees SSN are maintained and used by System for payroll and benefits purposes and reported to Federal and State agencies on forms for benefits purposes as required or permitted by law. Further disclosure of the employee’s SSN will be governed by the Public Information Act (Chapter 552 of the Texas Government Code).

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<tr>
<th>ADD</th>
<th>REMOVE</th>
<th>Relationship</th>
<th>Dependent's Last Name, First, MI</th>
<th>Soc. Sec. Number</th>
<th>Birth Date MMDDYYYY</th>
<th>Gender M/F</th>
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**SECTION J: ACKNOWLEDGEMENT OF DEFINITION OF A DEPENDENT**

Definition of Dependent: Your legally married spouse; unmarried child from birth under age 26 including: (A) an adopted child, (B) a stepchild, foster child, or other child who is in a regular parent-child relationship, (C) any such child, regardless of age, who lives with or whose care is provided by an employee or retired employee on a regular basis, if such child is incapacitated to such an extent as to be dependent upon the employee or retired employee for care or support, as the institution shall determine. It does not mean anyone who: (1) is active in the armed forces or any country; or (2) has coverage under any plan that receives a premium sharing contribution from the State of Texas. This includes any employee, retiree or dependent coverage under another University of Texas or Texas A&M plan, and any plan offered by a Texas state agency, and certain public school districts. If you want to cover a dependent other than your biological daughter, son or legally married spouse, you must complete a Special Dependent Application form. By signing the Authorization Section, I certify that all dependents listed above are eligible and are not covered under any plan that receives a State of Texas premium sharing contribution.

**SECTION K: AUTHORIZATION**

I understand that by signing this form, I am also consenting to the reduction of my monthly salary by the amount of premium that I am required to pay for coverage set forth on this form in which I have elected to enroll in compliance with Texas Insurance Code Section 1601.205. ANY SECTION LEFT BLANK INDICATES THAT I DID NOT SELECT THE COVERAGE.

Printed Name _____________________________ Employee Signature _____________________________

Date _____________________________