

**UNIVERSITY OF TEXAS AT ARLINGTON  
INSURANCE ENROLLMENT APPLICATION**

<p><b>OFFICE USE ONLY</b></p> <p>COMMENTS:</p>  <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>You may be entitled to know what information UT Arlington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.</p> </div>	<p><b>OFFICE USE ONLY</b></p> <p><input type="checkbox"/> Initial Application</p> <p><input type="checkbox"/> 31-Day Change</p> <p><input type="checkbox"/> Current Employee / Family Status Change</p> <p>Hire Date _____</p> <p>Health Coverage Effective Date _____</p> <p>Optional Coverage Effective Date _____</p> <p>Family Status Change Date _____</p> <p>Approved _____</p>	<p><b>OFFICE USE ONLY</b></p> <p><input type="checkbox"/> Staff                    <input type="checkbox"/> GTA</p> <p><input type="checkbox"/> Faculty                    <input type="checkbox"/> GRA</p> <p><input type="checkbox"/> Full Time Employee</p> <p><input type="checkbox"/> Part Time Employee</p>
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<p><b>Section 1</b></p> <p><b>NAME:</b> _____ (Last, First, MI)</p> <p><b>UTEID:</b> _____</p> <p><b>BIRTHDATE:</b> _____</p> <p><b>EMAIL ADDRESS:</b> _____</p> <p><b>ADDRESS:</b> _____</p> <p><b>CITY:</b> _____ <b>STATE:</b> _____ <b>ZIPCODE:</b> _____</p> <p><b>TELEPHONE NO: HOME</b> _____ <b>CAMPUS EXT</b> _____</p> <p><b>DEPARTMENT:</b> _____</p>	<p><b>Section 2</b></p> <p><input type="checkbox"/> <b>WAIVE ALL COVERAGE</b></p> <p><input type="checkbox"/> <b>WAIVE GROUP HEALTH COVERAGE **</b></p> <p><input type="checkbox"/> <b>I AM TAKING THE STUDENT INSURANCE</b></p> <p><small>**I certify that I have health coverage from a source outside of the University Of Texas System and that I, therefore, waive my right to enroll in The University of Texas System group Health coverage.</small></p> <p><small>I understand that if I wish to request this insurance at a later date, I can only do so during annual enrollment or within 31 days of a family status change. I further understand that any previously eligible dependents I may wish to enroll may be subject to evidence of insurability requirements.</small></p>
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<p><b>Section 3</b></p> <p><b>Basic Coverage</b> (For Full Time Employees Only)</p> <p><input type="checkbox"/> I want only the UTA paid coverages which includes:</p> <ol style="list-style-type: none"> <li>1. UT Select Health Coverage</li> <li>2. \$10,000 Group Term Life</li> <li>3. \$10,000 Accidental Death and Dismemberment</li> </ol>	<p><b>Section 4</b></p> <p><b>BENEFICIARY INFORMATION:</b> Please complete a separate <b>Beneficiary Form</b> for your <b>Term Life and Personal Accident Insurance</b></p> <p><b>UT FLEX ELECTION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO ( requires a separate FLEX enrollment form)</p> <p><b>LONG TERM CARE</b> Packets are available upon request or on the web at: <a href="http://www.utsystem.edu/benefits">http://www.utsystem.edu/benefits</a></p>
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<p><b>Section 5</b></p> <p><b>HEALTH PLAN**</b></p> <p><input type="checkbox"/> UT Select PPO</p> <p><input type="checkbox"/> HMO Blue</p> <p><small>**Health plan coverage is subject to a 90 day waiting period; however you must enroll within 31 days of initial eligibility or hire date. Plan changes can only be made during this 31 day initial eligibility period or during annual enrollment</small></p>	<p><b>Section 6</b></p> <p><b>HEALTH COVERAGE</b></p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee + Spouse *</p> <p><input type="checkbox"/> Employee + Children *</p> <p><input type="checkbox"/> Employee + Family *</p> <p><small>*EOI is generally required when adding any dependent after 31 days of employment.</small></p>	<p><b>Section 7</b></p> <p><b>DENTAL COVERAGE</b></p> <p><input type="checkbox"/> UT Dental Select / Delta</p> <p><input type="checkbox"/> Assurant/Fortis DMO</p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee + Spouse</p> <p><input type="checkbox"/> Employee + Children</p> <p><input type="checkbox"/> Employee + Family</p> <p><input type="checkbox"/> I DO NOT WANT DENTAL</p>	<p><b>Section 8</b></p> <p><b>VISION COVERAGE</b></p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee + Spouse</p> <p><input type="checkbox"/> Employee + Children</p> <p><input type="checkbox"/> Employee + Family</p> <p><input type="checkbox"/> I DO NOT WANT VISION</p>
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<p><b>Section 9</b></p> <p><b>GROUP TERM LIFE INSURANCE</b></p> <p><input type="checkbox"/> <b>\$10,000 Employee Only – Paid by UT System</b></p> <p><input type="checkbox"/> I Do Not Want Term Life</p> <p>Times Annual Salary: <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X* <input type="checkbox"/> 5X* <input type="checkbox"/> 6X*</p> <p>Spouse Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000* <input type="checkbox"/> \$50,000*</p> <p>Children \$10,000 Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p align="right"><small>* Evidence of Insurability Required</small></p>	<p><b>Section 10</b></p> <p><b>ACCIDENTAL DEATH AND DISMEMBERMENT (AD&amp;D)</b></p> <p><input type="checkbox"/> <b>\$10,000 Employee Only – Paid by UT System</b></p> <p><input type="checkbox"/> I Do Not Want AD&amp;D</p> <p><input type="checkbox"/> I request a fixed amount of \$_____ (\$10,000 increments)</p> <p><input type="checkbox"/> I request the Maximum Coverage (10x Salary / \$1,000,000 Maximum)</p> <p><input type="checkbox"/> I request the Maximum Spouse Coverage (50% of Employee Coverage)</p> <p><input type="checkbox"/> I request Spouse Coverage in a fixed amount of \$_____ (\$10,000 increments)</p> <p><input type="checkbox"/> I request Child(ren) coverage of \$10,000</p>
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<p><b>Section 11</b></p> <p><b>SHORT TERM DISABILITY</b></p> <p><input type="checkbox"/> I want Short Term Disability</p> <p><input type="checkbox"/> I Do Not Want Short Term Disability</p>	<p><b>Section 12</b></p> <p><b>LONG TERM DISABILITY</b></p> <p><input type="checkbox"/> I want Long Term Disability</p> <p><input type="checkbox"/> I Do Not Want Long Term Disability</p>
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I hereby request my employer to arrange for the issuance of the insurance to which I am now eligible and authorize my employer to make the proper premium redirections from my earnings as my contributions toward the cost of these benefits under UTFLEX. I acknowledge I have received information about and am eligible for COBRA health plan continuation coverage. I understand that I can only make changes during an Annual Enrollment period or within 31 days of a Family Status Change (as defined by the IRS).

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_