

UT EID	Name (Last, First, MI)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth			
Circle one: UTSA E-mail Address Home E-mail Address		Note: If you do not have a UTSA e-mail address, you may list your home e-mail address, however, it will appear in the faculty/staff directory, which is on the UTSA website and available to the public.					
1. Are you enrolled in another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. If you are electing coverage for your spouse and/or children, are they enrolled in another medical plan? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to one or both questions, please provide the name of employer or agency providing medical plan: _____		Have you ever been offered ORP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____ Are you a current participant of TRS or ORP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle one: TRS or ORP Are you a retiree of either the TRS or ORP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle one: TRS or ORP If you are a TRS retiree, are you aware of TRS' Provisions for "Employment After Retirement"? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Long-Term Care Plan: I understand that I will have 31 days from my benefits-eligible date to enroll in the Long-Term Care Plan and enrollment into the Long-Term Care Plan will require that I complete and mail the Employee Enrollment Form to CNA within the 31-day deadline. Initials: _____							
Automatic Coverage (UT Select/Blue Cross Blue Shield Medical PPO, 10k Life and 10k Personal Accident)		<input type="checkbox"/> I elect the Automatic Coverage Package	<input type="checkbox"/> I decline the Automatic Coverage Package	Effective Date			
If you elect ed the automatic coverage package, then STOP here and sign below on Subscriber's Signature line. If you declined the automatic coverage package, mark an "X" in the appropriate box for each plan listed below							
PLAN NAME	DECLINE COVERAGE	CANCEL COVERAGE	SUBSCRIBER ONLY	SUBSCRIBER & SPOUSE	SUBSCRIBER & CHILD(REN)	SUBSCRIBER & FAMILY	EFFECTIVE DATE MO/DAY/YEAR
UT Select/PPO Health Plan Includes 10K Life, 10K ADD							
Delta Dental Plan							
Assurant Dental Plan							
Superior Vision Plan							
Life Insurance Plan				N/A	N/A		
Personal Accident Insurance				N/A	N/A		
Long-Term Disability Plan				N/A	N/A	N/A	
Short-Term Disability Plan				N/A	N/A	N/A	
Life Insurance Election for Employee: <u>EOI Required</u> <input type="checkbox"/> 1 x Salary <input type="checkbox"/> 4 x Salary <input type="checkbox"/> 2 x Salary <input type="checkbox"/> 5 x Salary <input type="checkbox"/> 3 x Salary <input type="checkbox"/> 6 x Salary Dependent Options: <input type="checkbox"/> Option 1: \$10,000 each dependent <input type="checkbox"/> Option 2: \$25,000 spouse + \$10,000 each child <input type="checkbox"/> Option 3: \$50,000 spouse + \$10,000 each child			Personal Accident Insurance Election(s) for Employee: <input type="checkbox"/> Employee coverage to be <u>automatically</u> updated to maximum amount: \$ _____ <input type="checkbox"/> Employee coverage to be a <u>fixed</u> amount: \$ _____ Dependent Options: <input type="checkbox"/> Dependent coverage to be <u>automatically</u> updated to maximum amount: \$ _____ <input type="checkbox"/> Dependent's coverage to be a <u>fixed</u> amount: \$ _____				
If you are declining medical coverage, do you want to use Premium Sharing dollars to pay for other optional insurance plans? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Eligible; I have other medical coverage, which is state-funded. (Examples: another state agency or community college)							
I authorize The University of Texas at San Antonio to deduct the appropriate premiums from my payroll check. I understand that if I am a full-time employee or graduate student who elects subscriber only medical coverage, I will have no out-of-pocket medical premium cost. However, if my appointment changes to a part-time benefits-eligible staff or faculty title, I authorize The University of Texas at San Antonio to deduct the appropriate medical premium for part-time employees. I have reviewed and understand the rates listed on the Benefits Cost Worksheet.							
Subscriber's Signature: _____			Date: _____				
Witness' Signature: _____			Date: _____				

HR USE ONLY:

PRIVACY NOTICE: With a few exceptions, you are entitled to be informed about the information U.T. San Antonio collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review this information. Under Section 559.004 of the Texas Government Code, you are entitled to have U.T. San Antonio correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in the University of Texas System Business Procedures Memorandum 32. The information that U.T. San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441 180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.
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