

UT Health Science Center San Antonio

Insurance Election Form

FY 2008-2009

Name: _____ Date of Employment: ____/____/____
Last, First, MI (as listed on Social Security Card)

Annual Compensation: _____

NOTE: Full time employees are **automatically defaulted** to medical coverage with free \$10,000 term Life and \$10,000 Accidental Death and Dismemberment coverage without an out-of-pocket cost. If you are **full time** and wish to have this automatic coverage only, you do not need to complete this form. If you are part-time and benefits eligible you *will not* be defaulted to any coverage. To sign up for, or to add coverage, please complete this form as thoroughly as possible.

OUT-OF-POCKET COST (PER MONTH)

MEDICAL PLAN – FULL TIME	Employee	Employee & Spouse	Employee & Children	Employee & Family
UT Select (BCBS) PPO <small>Includes \$10K basic life and \$10k basic AD&D</small>	\$0.00	\$158.86	\$166.15	\$312.85

MEDICAL PLAN – PART TIME	Employee	Employee & Spouse	Employee & Children	Employee & Family
UT Select (BCBS) PPO <small>Includes \$10K basic life and \$10k basic AD&D</small>	\$184.58	\$440.13	\$412.58	\$656.57

DENTAL PLAN	Employee	Employee & Spouse	Employee & Children	Employee & Family
UT Dental Select (Delta)	\$28.26	\$53.65	\$59.14	\$84.09
Assurant Dental DMO	\$10.05	\$19.10	\$21.11	\$30.15

VISION PLAN	Employee	Employee & Spouse	Employee & Children	Employee & Family
Superior Vision	\$7.36	\$11.48	\$11.74	\$18.90

OPTIONAL BENEFITS COVERAGE

A. Fort Dearborn Term Life Insurance

Subscriber's Date of Birth: ____/____/____ Subscriber's Age: _____

NOTE: Maximum coverage: \$1.5 million. **Evidence of insurability required for coverage greater than three (3) times your earnings.** The cost table is located in your [Employee Handbook](#), on page 72.

OPTIONS:

Or select: 1X salary 2X 3X | Face Value: \$_____ Monthly Cost: \$_____

I WOULD LIKE TO DECLINE LIFE INSURANCE COVERAGE

B. Fort Dearborn Dependent Term Life

NOTE: NOTE: Coverage cannot be elected without Employee coverage. \$10K of basic life insurance for spouse and child(ren) at a rate of \$2.87 per month. **To add coverage for an additional \$15K or \$45K, proof of health is required.**

I WOULD LIKE TO ADD SPOUSE COVERAGE (\$10K TOTAL)

I WOULD LIKE TO ADD CHILD/REN COVERAGE (\$10K TOTAL)

I WOULD NOT LIKE TO ADD DEPENDENT LIFE COVERAGE AT THIS TIME.

C. Fort Dearborn Accidental Death & Dismemberment (AD&D)

NOTE: You may select coverage at up to 10 times your salary, not to exceed \$1 million. **Coverage cost is \$0.16 per \$10K.**

SUBSCRIBER SUPPLEMENTAL: \$_____ (Minimum \$20K in multiples of \$10K)

DEPENDENT COVERAGE - CHILD: I WOULD LIKE TO ADD DEPENDENT CHILD/REN (\$10K TOTAL)

I WOULD NOT LIKE TO ADD CHILD/REN AT THIS TIME

DEPENDENT COVERAGE - SPOUSE: YES NO

If yes, please indicate amount below. **NOTE: Spouse cannot have more than half of employee coverage selection.**

AMOUNT: \$_____

I WOULD NOT LIKE TO ADD AD&D COVERAGE AT THIS TIME

D. Hartford Long and Short Term Disability

LONG TERM DISABILITY (Your monthly salary x \$0.0041)

SHORT TERM DISABILITY (Your monthly salary x \$0.0051)

I WOULD NOT LIKE TO ADD LTD OR STD COVERAGE AT THIS TIME

E. Flexible Spending Accounts

MEDICAL EXPENSE REIMBURSEMENT (If yes, enter monthly amount: \$_____)

DAY CARE REIMBURSEMENT (If yes, enter monthly amount: \$_____)

I DO NOT WISH TO PARTICIPATE AT THIS TIME

(sign and date on next page)

I have reviewed the insurance options I have selected and/or changed on this Form for accuracy. I authorize my employer to make the proper deductions from my earnings as my contribution toward the cost of these benefits. Also, I understand that no refund of premiums can be made for failure to notify the Office of Human Resources of a drop in coverage due to a change in status.

Signature

Date signed

Witness

Date signed

NOTE: If adding child(ren) and/or spouse to any of the coverage selections, please fill out the Dependent Designation Form (see [Step 2](#)) as soon as possible to validate your insurance.