University Health

Employee ID

2025 Benefit Election Form

Last Name	First Name	M.I.	Social Security Number	Phone Number
Street Address	**City**	**State**	**Zip**	**Email**

For all Qualifying Events: Submit completed form and proper supporting documentation to **UHS.Benefits@uhtx.com**. Your change will not be processed without proper documentation attached or if you fail to notify Human Resource within 31 days of your qualifying event.

❑ New Hire ❑ Birth/Adoption/New Legal Guardianship ❑ Gain or Loss of Coverage (Spouse/Dependent) ❑ Death of Dependent

❑ Marriage ❑ Divorce/Legal Seperation ❑ Change in Employment Status ❑ Other Reason

Medical Enrollment:

University Family Care Plan

❑ Employee Only ❑ Employee & Spouse/Domestic Partner ❑ Decline

❑ Employee & Child(ren) ❑ Employee & Family

Dental Enrollment: (Choose One from the 4 Plans Listed below)

Humana DHMO

❑ DHMO

Humana DPO

❑ Bronze Plan
❑ Silver Plan
❑ Gold Plan

Coverage Level

❑ Employee Only
❑ Employee & Child(ren)
❑ Employee & Spouse/Domestic Partner
❑ Employee & Family

❑ Decline

Vision Enrollment:

EyeMed Vision

❑ Employee Only ❑ Employee & Spouse/Domestic Partner ❑ Decline

❑ Employee & Child(ren) ❑ Employee & Family

Short-Term Disability

❑ 50%
❑ 60%
❑ 70%
❑ Decline

Long-Term Disability

❑ 50%
❑ 60%
❑ Decline

Dependent Life Insurance

❑ $10,000 Spouse/ $5,000 Child(ren)
❑ $20,000 Spouse/$10,000 Child(ren)
❑ $30,000 Spouse/$15,000 Child(ren)
❑ $40,000 Spouse/$20,000 Child(ren)
❑ $50,000 Spouse/$25,000 Child(ren)

❑ Decline

Name	Relationship	D.O.B	Gender (M/F)	SSN	Primary PCP	Primary Dentist (DHMO only)	Medical (Y/N)	Dental (Y/N)	Vision (Y/N)	Cancer (Y/N)	Dep. Life (Y/N)
	Self	On Record	On Record	On Record							N/A

Flexible Spending Account (Minimum Annual Enrollment $100.00)

❑ Medical FSA Annual Pledge: $_____

❑ Dependent Care FSA Annual Pledge: $_____

❑ Decline

Supplemental Term Life Insurance

❑ 1x Annual Salary ❑ 5x Annual Salary

❑ 2x Annual Salary ❑ 6x Annual Salary

❑ 3x Annual Salary ❑ 7x Annual Salary

❑ 4x Annual Salary ❑ Decline

Assign Beneficiaries for the following Plans: (please print clearly)

Basic Life Insurance Beneficiary	**Type**	**%**	**Relationship**	**Date of Birth**	**Address**	**Phone Number**
	Primary					
	Primary					
	Contingent					
	Contingent					
Supplemental Life Insurance Beneficiary	**Type**	**%**	**Relationship**	**Date of Birth**	**Address**	**Phone Number**
	Primary					
	Primary					
	Contingent					
	Contingent					
Cancer Beneficiary	**Type**	**%**	**Relationship**	**Date of Birth**	**Address**	**Phone Number**
	Primary					
	Primary					
	Contingent					
	Contingent					

Aflac Cancer ❑ **$10,000** ❑ **$20,000** ❑ **$30,000** ❑ **$40,000** ❑ **$50,000**

❑ **Basic Cancer Plan**

❑ Employee Only ❑ Employee & Spouse/Domestic Partner

❑ Employee & Child(ren) ❑ Employee & Family ❑ Decline

Aflac Cancer ❑ **$10,000** ❑ **$20,000** ❑ **$30,000** ❑ **$40,000** ❑ **$50,000**

❑ **Enhanced Cancer Plan**

❑ Employee Only ❑ Employee & Spouse/Domestic Partner

❑ Employee & Child(ren) ❑ Employee & Family ❑ Decline

I certify that I am, and each of my enrolled dependents is, eligible to participate in plans elected for us on this form, as eligibility is defined in each plan. I understand that my benefit elections cannot be changed or revoked before the next open enrollment, unless there is an appropriate status change (such as change in legal marital status, number of dependents, employment status, dependent eligibility, change of residence, or COBRA) or other permitted event such as court order, HIPPA enrollment rights, Medicare/Medicaid eligibility, or significant cost or coverage change. Changes must be requested and documented within 31 days of the event.

AUTHORIZATION: I hereby authorize my licensed physician, hospital, pharmacy, clinic, health care facility, insurance company, employer, or organization to release to University Health or its agents any information regarding me or my enrolled family members' medical history, treatment, and/or disability that is reasonably necessary for the purpose of utilization review, coordination of benefits, or payment of a claim. The authorization shall cease to be effective at such time when my coverage under the plan terminates. In the event that I have any outstanding claims at time of termination, the authorization will continue to apply until all the claims have been settled. I understand that University Health will automatically deduct from my wages the amount of any co-pays I or my dependents incur as a result of receiving medical services or supplies from University Health or any sponsored group health plan, and I give my authorization for such deductions. In addition, in the case of coverage I have elected under any plan indicated with above, I authorize payment of the applicable premiums by means of payroll deduction on a pre-tax basis. For all other plans, I authorize payment of the applicable premiums by means of payroll deduction on an after-tax basis. I hereby attest that the statements made by me are true, and I understand that any material misstatements may be used to contest the validity of my benefits. Proof of dependent status must be submitted for dependents in order to maintain coverage.

Employee Signature:	Date:

Office Use Only: Date Received:	Initials:	Date Keyed: