The University of Texas at El Paso
GRADUATE STUDENT EMPLOYEES
Insurance Enrollment & Waiver Form

Employee/Student Data - Please Print Legibly

Classification: □ Graduate Student Employee

80# □ EMPL ID:

Last Name □ First Name □ Middle

Gender: □ Male □ Female

Date of Birth: □ UTEP e-mail:

Employment Start Date (Student Employees Only):

Street Address □ City □ State □ Zip Code

Home Phone Number/UTEP Extension: □ Department:

U.S. Citizen/Resident? □ Yes □ No

If NO please complete section B

*Student employees are given the option to enroll in either Academic Health Plans (Section A), premiums are paid for by UTEP, or UT Select (Section C), which requires student employees to pay monthly premiums. If you choose the UT Select option please ask for a UTEP Benefits Handbook at the Human Resource Services front desk.

Section A: Academic Student Health Insurance Enrollment Application (Student Employees Only)

Medical Plan

□ SHIP - Academic Student Health Insurance Plan (Student employees pay no monthly premiums)

□ Optional Coverage (UT Select, Dental, Vision etc. all; rates will apply)

I elect insurance coverage for the following Semester(s):

□ Fall 2014 □ Spring 2015 □ Summer 2015

Section B: Health Insurance Fee Waiver *(Mandatory ONLY for International Student Employees)*

Acceptable Proof of Insurance:

□ SHIP Group # 101570

□ UT Select Dependent Coverage – Name of UTEP Employee __________________________________________

□ Other: ___________________________ Dates of Coverage ___________________________

□ Evacuation and Repatriation included □ Evacuation and Repatriation Not Included ($40 fee per semester)

*I acknowledge that I have until census day of every semester (Census day information can be found in the Schedule of classes) to submit my Insurance Waiver. I further understand that if documentation is not submitted in a timely matter, the waiver will not be validated and I will be responsible for the health Insurance fee assessed by the University and will not be eligible for a refund of the Health Insurance fee.

STUDENT SIGNATURE __________________________ DATE __________

FOR HRS USE

Appointment Status: __________________________ HRS REP __________ DATE __________

Began Date _________ End Date: __________ HRS/WK _________ %Time _________

Section C: UT SELECT Enrollment Application
## Rates Apply - Voluntary Coverages for Graduate Student Employees

### Medical Plan
- **UT Select**
- **Waive (with proof of insurance)**
- **Decline**

### Dental Plan
- **Dental HMO**
- **Delta Dental**
- **Delta Plus Plan**
- **Decline Dental Coverage**

### Vision Plan
- **Superior Vision**
- **Superior Plus Plan**
- **Decline Vision Coverage**

### Long Term Disability
- **Long Term Disability**
- **Decline Long Term Disability**

### Short Term Disability
- **Decline Short Term Disability**

### Term Life Insurance
- **Employee Voluntary GTL (1-3 x's) Annual Earnings**
- **Employee Voluntary GTL (4-6 x's) Annual Earnings (EOI Required)**
- **Decline Voluntary Term Life Insurance**

### Voluntary Dependent Coverage
- **Option 1- $10,000/$10,000**
- **Option 2- $25,000/$10,000 (Spouse EOI Required)**
- **Option 3- $50,000/$10,000 (Spouse EOI Required)**
- **Decline Voluntary Dependent Coverage**

### Accident Death & Dismemberment Insurance
- **Employee Voluntary AD&D $______________**
- **Employee Maximum AD&D (based upon present earnings)**
- **Decline AD&D Insurance**

### Voluntary Dependent Coverage
- **Voluntary Dependent AD&D Coverage $______________**
- **Decline Voluntary Dependent Coverage**

### Summer Notice:
I understand that if I am not appointed/assigned during the summer, I will not be eligible for summer medical insurance coverage. Further, I understand that if not employed in a benefit eligible position, I will be responsible for the full cost of premiums for June, July, and August through COBRA.

**Signature:** ___________________________  **Date:** ___________________________

### Payroll Deduction Authorization:
I hereby authorize UTEP to deduct the sum of $______________ per month which represents the difference between the amount appropriated by this institution's budget and the cost of my selected coverage. If I wish to make changes to my elections, I have an opportunity to make changes at the beginning of each semester.

**Signature:** ___________________________  **Date:** ___________________________
Notice of Information for those choosing to enroll in

*Academic Student Health Insurance Plan*

FOR ALL GRADUATE UTEP STUDENTS

Dependent Enrollment:  Customer Service:  Claims:
Academic Health Plans, Inc.  Blue Cross Blue Shield of Texas  Blue Cross Blue Shield of Texas
P.O. Box 1605  P.O. Box 660044  P.O. Box 660044
Colleyville, TX 76034  Dallas, TX 75266-0044  Dallas, TX 75266-0044
(855) 247-7587 Toll Free  (800) 267-0214 Toll Free  (800) 451-0287 Toll Free
(817) 809-4701  (888) 267-0214 Toll Free  (888) 308-7320 Toll Free

**WHAT DOES THE INSURANCE COVER:** The Academic Student Health Insurance Plan is a comprehensive PPO plan which meets the Affordable Care Act requirements of essential coverage. When you enroll in the Academic Medical Plan, the Prescription Drug Coverage is included as part of your enrollment. The plan is administered by Blue Cross Blue Shield, there is no benefit maximum for either the medical or prescription plan and it has a $500.00 deductible (per school year per insured person). Academic Student Health Insurance Plan will pay 80% for In-Network Providers or 60% for Out-of-Network Providers after the deductible has been met. For more detailed information about this plan, please go to:
http://utep.myahpcare.com/benefits

Enrollment and insurance cards can be obtained via the above-mentioned website.

In the event of a medical emergency call Academic Emergency Services (multilingual call center): 1-855-464-8975 (USA or Canada) or 1-603-328-1362 Collect outside of the USA.

Blue Care Connection- 24/7 Nurseline (866) 412-8795

**WHAT DOES IT COST?** See schedule below.

**2014-2015 PREMIUM AMOUNTS**

<table>
<thead>
<tr>
<th></th>
<th>Student</th>
<th>Student EE</th>
<th>Spouse</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual (8-15-2014 to 8-14-2015)</strong></td>
<td>$1,859</td>
<td>$0</td>
<td>$7,125</td>
<td>$4,753</td>
</tr>
<tr>
<td><strong>Fall (8-15-2014 to 12-31-2014)</strong></td>
<td>$708</td>
<td>$0</td>
<td>$2,713</td>
<td>$1,810</td>
</tr>
<tr>
<td><strong>Spring (1-01-2015 to 5-31-2015)</strong></td>
<td>$770</td>
<td>$0</td>
<td>$2,949</td>
<td>$1,968</td>
</tr>
<tr>
<td><strong>Spring/Summer (1-01-2015 to 8-14-2015)</strong></td>
<td>$1,151</td>
<td>$0*</td>
<td>$4,412</td>
<td>$2,943</td>
</tr>
<tr>
<td><strong>Summer (6-01-2015 to 8-14-2015)</strong></td>
<td>$382</td>
<td>$0*</td>
<td>$1,465</td>
<td>$977</td>
</tr>
</tbody>
</table>

*Only with summer assignment that is considered a benefits-eligible position.*
Notice of Personal Information for those choosing to enroll in UT Select Benefits

The following notice is provided in accordance with Section 559.003(a) of the Texas Government Code:

1. With few exceptions, you are entitled on your request to be informed about the information The University of Texas System Administration collects about you;
2. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information; and
3. Under Section 559.004 of the Texas Government Code, you are entitled to have The University of Texas System Administration correct information about you that is held by The University of Texas System Administration and that is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32, Texas Public Information Act.

The information that The University of Texas System Administration 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.

Please remember that this form only provides you (the subscriber) with an estimate of your total out-of-pocket cost per month based on state-appropriated funds and contracted premium rates.

2014-2015 PREMIUM AMOUNTS

<table>
<thead>
<tr>
<th>MEDICAL OUT-OF-POCKET COST PER MONTH:</th>
<th>PART-TIME EMPLOYEES ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Available - Worldwide</td>
<td>Subscriber Only</td>
</tr>
<tr>
<td>UT SELECT</td>
<td>$263.70</td>
</tr>
</tbody>
</table>

(Administered by Blue Cross & Blue Shield of Texas)

Medical Plan Rates Include: $20,000 Life & $20,000 AD&D

Part-time = Appointed for at least 20 hours but less than 40 hours per week