Texas Christian University
Human Resources Department
Benefit Enrollment

Instructions *- If you do not select a benefit option, write "Waive" and initial in the "Effective Date" box for that plan. Please complete both sides.*

Name				**TCU ID#**	
Home Address				**Home Phone**	
City, State, Zip				**Work Phone**	
Department				***Circle One:***	**Biweekly** **Monthly**
Hire Date		**TCU Box**		***Circle One:***	**Full Time** **Part Time***

Benefits - Circle plan option desired.

Voluntary Life Plan ***Mutual of Omaha***	**Effective Date**	**$25,000**	**$50,000**	**1X Salary**	**2X Salary**	**3X Salary**	**4X Salary**

Dependent Life Plan ***Mutual of Omaha*** **(Employee must purchase Voluntary Life to purchase Dependent Coverage.)**	**Effective Date**		
		Spouse- up to 50% of Employee Voluntary Life (multiples of $5,000.00)	**Amount:**
		Children- Maximum Benefit $10,000.0 (multiples of $1,000.00)	**Amount:**

Long-Term Disability ***Mutual of Omaha***	**Effective Date**	**60%**	**70%**

Medical Plan ***CARES# 066446*** **PPO90** **PPO80** **PPO70** **HDHP**	**Effective Date**	**Employee Only**	**Employee and Spouse**	**Employee and Children**	**Employee and Family**

Prescription Buy up (does not apply to HDHP)
Express Scripts
YES **NO**

Dental Plan ***CIGNA # 3215812*** **DHMO** **PPO**	**Effective Date**	**Employee Only**	**Employee and Spouse**	**Employee and Children**	**Employee and Family**

Vision Plan *United Healthcare # A941*	**Effective Date**	**Employee Only**	**Employee and Spouse**	**Employee and Children**	**Employee and Family**

Employee & Dependent Coverage information ***Complete all information for individuals you wish to cover for Health, Dental and Dependent Life (check box)***.

Name (First, Middle Initial, Last)	Relation-ship	Social Security Number	Birth-date	Sex	Dentist's Name and ID Number (Only if enrolled in DHMO)	Dependent Life (☐)

Beneficiary Designation – MUST BE COMPLETED EVEN IF NO OPTIONAL LIFE INSURANCE ELECTED

Name (First, Middle Initial, Last)	Relation-ship	Social Security Number	Birth-date	Sex	Basic		Supplemental	
					Percent of Benefit	Primary or Contingent	Percent of Benefit	Primary or Contingent

I authorize TCU to adjust my paycheck

I have enrolled in the coverages indicated above. I authorize TCU to adjust my paycheck by the required contribution for these coverages. Medical, Dental and Vision contributions will be deducted on a pre-tax basis. Deductions will continue until this agreement is amended or terminated.

Signature **Date**