



**University of Texas System Medical Foundation  
2009-2010 Plan Year Medical Enrollment Form**  
Group ID: UTSMF

**FOR OFFICE USE ONLY:** Employee Original Effective Date of Coverage: \_\_\_\_\_  
Late Enrollee: ( ) Yes or ( ) No Dependent Original Effective Date of Coverage: \_\_\_\_\_

**I. Employee Information:**  
Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First MI  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: ( ) Male ( ) Female Marital Status: ( ) Married ( ) Single ( ) Divorced  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip Code Home  
Hire Date & Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**II. COVERAGE ELECTION - Select type of coverage you wish and list the dependents you are covering in Section III.**

**Medical:**  
( ) MHHNP- EPO ( ) Employee Only ( ) Employee+Spouse ( ) Employee+Child(ren) ( ) Employee+Family  
( ) PHCS - PPO ( ) Employee Only ( ) Employee+Spouse ( ) Employee+Child(ren) ( ) Employee+Family

**III. Spouse / Dependent Information:**  
Use the relationship codes to indicate each dependent's relationship to you (H, W, S, D, or O). H=Husband, W=Wife, S=Son, D=Daughter, O=Stepchild

| Last Name | First Name | MI | Social Security# | Birthdate | Sex | Relationship |
|-----------|------------|----|------------------|-----------|-----|--------------|
|           |            |    |                  |           |     |              |
|           |            |    |                  |           |     |              |
|           |            |    |                  |           |     |              |
|           |            |    |                  |           |     |              |
|           |            |    |                  |           |     |              |
|           |            |    |                  |           |     |              |

**Definition of a Dependent**

An eligible dependent is a legal spouse, an unmarried child under the age of 19 who is dependent on you for support; an unmarried child age 19 up to 25, who is dependent on you for support; an unmarried child of any age who lives with you, is dependent on you for support, and is physically or mentally incapable of supporting themselves due to a total disability. Any child who is required to be treated as your dependent under a qualified medical child support order (QMCSO).

1. Are your dependents covered under any Federal, State, or Government Plan (including Medicare/Medicaid)?  
2. Does the other group plan have Coordination of Benefits?  
3. Is there a divorce order stating who is responsible for coverage for dependents?  
If "Yes", name the responsible party: \_\_\_\_\_  
4. Is your spouse employed?  
If you answered "Yes" to any of the above questions, please provide the following information:  
Name and phone # of spouse's employer: \_\_\_\_\_  
Name & phone number of other Insurance Company: \_\_\_\_\_  
Name of the Employer or group providing the plan: \_\_\_\_\_  
Name of the person(s) covered under this plan: \_\_\_\_\_

**Approval**  
I have read the explanations of my benefit options. I authorize the above elections and the required contributions for these elections. I understand that I cannot change or revoke any of these indicated elections during the plan year unless there is a Change In Family Status as defined by the Internal Revenue Service (IRS). If I elect not to participate in the medical plan, I understand and agree that UTSMF is not liable for medical expenses that would otherwise be covered by UTSMF's medical plan. I certify that the information above is true and can show proof if requested. I understand that any falsification can be considered grounds for termination.

\_\_\_\_\_  
Employee Signature Date  
\_\_\_\_\_  
Employer Signature Date