ONLINE VERSION

FULL TIME
Newly Hired/Newly Eligible
2024 Benefit Enrollment Form

Full Name: _____

Team Member Number: _____

***Be sure to sign your form at the end of this packet

Once Completed
Email All Pages to:
TOTALBENEFITS@UNITEDTEXAS.COM
or fax to: (806) 791-6341

Section I – Benefit Plans *Refer to your 2024 guidebook for more information.

All Rates are Per Week

MEDICAL PLAN ELECTION ☐ Waive

Please select:

Deductibles	$1,500/$4,500	$2,000/$4,000	$900/$1,800
Coverage	**EPO PLAN**	**HSA PLAN**	**PPO PLAN**
Team Member Only	☐ $ 10.20	☐ $ 18.95	☐ $ 25.32
Team Member + Spouse	☐ $ 86.70	☐ $ 64.18	☐ $131.19
Team Member + Children	☐ $ 30.60	☐ $ 39.87	☐ $ 61.97
Family	☐ $122.40	☐ $ 83.25	☐ $164.61

HEALTH SAVINGS ACCOUNT PLAN ELECTION ☐ Waive

MUST ENROLL IN HSA MEDICAL PLAN

☐ Health Savings Account Amount Individual $ _____

☐ Health Savings Account Amount Family $ _____

- **You can elect up to $4,150 individual/$8,300 family**
- **Weekly deductions are based on election and the total weeks left in the plan year.**

FLEXIBLE SPENDING ACCOUNT ELECTION ☐ Waive

***Must not be enrolled in the HSA Medical Plan in order to participate*

☐ FSA Health $ _____

☐ FSA Dependent Day Care $ _____

- **You can elect up to $3,200 FSA Health and $5,000 for DCFSA Self/Married or $2,500 if married, but filling separately.**
- **Weekly deductions are based on election and the total weeks left in the plan year.**

DENTAL PLAN ELECTION ☐ Waive

Please select:

Coverage	Delta Basic	Delta Enhanced	Delta Enhanced Plus
Team Member Only	☐ $ 1.93	☐ $ 5.34	☐ $ 7.17
Team Member + Spouse	☐ $ 6.61	☐ $13.77	☐ $18.08
Team Member + Children	☐ $ 5.76	☐ $12.24	☐ $14.91
Family	☐ $10.45	☐ $20.68	☐ $26.50

VISION PLAN ELECTION ☐ Waive

Please select:

Coverage	Vision Standard	Vision Premier
Team Member Only	☐ $1.13	☐ $1.84
Team Member + Spouse	☐ $2.26	☐ $3.67
Team Member + Children	☐ $2.52	☐ $4.10
Family	☐ $4.03	☐ $6.54

UNUM ACCIDENT PLAN ELECTION ☐ Waive

Please select:

Coverage	Rate
☐ Team Member Only	$2.36
☐ Team Member + Spouse	$4.17
☐ Team Member + Children	$5.34
☐ Family	$7.15

CRITICAL ILLNESS EMPLOYEE PLAN ELECTION ☐ Waive

Please select:

☐ $5,000	☐ $10,000	☐ $15,000
☐ $20,000	☐ $25,000	☐ $30,000

CRITICAL ILLNESS SPOUSE PLAN ELECTION ☐ Waive

Please select:

☐ $5,000	☐ $10,000	☐ $15,000
☐ $20,000	☐ $25,000	☐ $30,000

Spouses can only get 100% of the employee coverage amount as long as you have purchased coverage for yourself.

HOSPITAL INDEMNITY PLAN ELECTION ☐ Waive

Please select:

High

☐ Team Member Only	$ 4.63
☐ Team Member + Spouse	$ 8.84
☐ Team Member + Children	$ 7.12
☐ Family	$11.34

Low

☐ Team Member Only	$2.85
☐ Team Member + Spouse	$5.25
☐ Team Member + Children	$4.32
☐ Family	$6.71

Dependents to be covered:

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

☐ **Add** ☐ **Cancel**
Dependent Name: ____ **Gender:** ☐ **M** ☐ **F**
SS#: ____-______-______ **DOB:** ___/____/____ **Relationship:** ☐**Child** ☐**Spouse**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Accident** ☐ **Critical Illness** ☐ **Hospital Indemnity**

**For additional dependents, please attach a separate sheet.*

Section II – Disability Plans

SHORT TERM DISABILITY PLAN ELECTION (Company Paid)

*Full Time Team Members are automatically enrolled 1st day of the month coinciding with or next following 12 month(s) of employment. (Team Member Only)

LONG TERM DISABILITY PLAN ELECTION ☐ Waive

☐ Elect coverage (Team Member Only)

Section III – Life Insurance Plans

BASIC LIFE AND BASIC LIFE AD&D (COMPANY PAID) – AUTOMATICALLY ENROLLED

Basic Life - 2X Annual Base Salary up to $1,000,000
Basic Life AD&D - .50 annual base salary

VOLUNTARY EMPLOYEE LIFE INSURANCE ELECTION ☐ Waive

1x to 8x annual base salary, up to $2,000,000 (up to $3,000,000 combined Basic Life + Optional Life)
Guaranteed Issue Amount: Lesser of 3x annual base salary or $1,000,000

Coverage Amount please select:

☐ 1 X Salary	☐ 2 X Salary	☐ 3 X Salary	☐ 4 X Salary
☐ 5 X Salary	☐ 6 X Salary	☐ 7 X Salary	☐ 8 X Salary

VOLUNTARY SPOUSE LIFE INSURANCE ELECTION ☐ Waive

☐ Coverage Amount $ _____ (Increments of $10,000 up to $500,000 - you must elect supplemental life for yourself, in order to cover your spouse/domestic partner)
Guaranteed Issue Amount: $50,000

VOLUNTARY CHILD LIFE INSURANCE ELECTION ☐ Waive

☐ Coverage Amount $ _____ ($5,000 to $20,000 in $5,000 increments – you must elect coverage for yourself in order to cover your child(ren))

VOLUNTARY EMPLOYEE LIFE AD&D INSURANCE ELECTION ☐ Waive

1X - 10X annual salary not to exceed $2,000,000
Coverage Amount please select:

☐ 1 X Salary	☐ 2 X Salary	☐ 3 X Salary	☐ 4 X Salary	☐ 5 X Salary
☐ 6 X Salary	☐ 7 X Salary	☐ 8 X Salary	☐ 9 X Salary	☐ 10 X Salary

VOLUNTARY FAMILY LIFE AD&D INSURANCE ELECTION ☐ Waive

☐ Elect: Coverage Amount _____
Spouse Only – 75% of Employee AD&D
Child Only – 20% of Employee AD&D
Family – 70% of Employee AD&D

Beneficiaries for Life Insurance

Beneficiary Name: ____

SS#: ____-_____-______ **DOB:** ____/____/____ **Relationship:** ☐Child ☐Spouse ☐Other

Gender: ☐ M ☐ F ☐ Primary ☐ Contingent ______%

Beneficiary Name: ____

SS#: ____-_____-______ **DOB:** ____/____/____ **Relationship:** ☐Child ☐Spouse ☐Other

Gender: ☐ M ☐ F ☐ Primary ☐ Contingent ______%

Beneficiary Name: ____

SS#: ____-_____-______ **DOB:** ____/____/____ **Relationship:** ☐Child ☐Spouse ☐Other

Gender: ☐ M ☐ F ☐ Primary ☐ Contingent ______%

Beneficiary Name: ____

SS#: ____-_____-______ **DOB:** ____/____/____ **Relationship:** ☐Child ☐Spouse ☐Other

Gender: ☐ M ☐ F ☐ Primary ☐ Contingent ______%

Beneficiary Name: ____

SS#: ____-_____-______ **DOB:** ____/____/____ **Relationship:** ☐Child ☐Spouse ☐Other

Gender: ☐ M ☐ F ☐ Primary ☐ Contingent ______%

Please ensure dependent verification documents are emailed to totalBenefits@unitedtexas.com, or faxed (806-791-6341) to the Benefits Department within 60 days or coverage will be dropped on dependents. Thank you.

Email: ____ **Phone:** _____________________

Signature: ____ **Date:** __________________