Texas Christian University
Human Resources Department
2020 Benefits Enrollment Form

Name		**TCU ID#**		
Home Address		**Home Phone**		
City, State, Zip		**Work Phone**		
Hire Date		**Payroll Frequency**	☐ **Biweekly**	☐ **Monthly**

Benefits – Check the box with the plan option desired

Medical Plan ☐ **PPO80** ☐ **CDHP** ☐ **HDHP with HSA** **Annual Contribution $_____** **Eff. 1st of the mo. following hire**	**Employee Only** ☐	**Employee and Spouse** ☐	**Employee and Children** ☐	**Employee and Family** ☐	**Decline Medical Coverage** ☐	
Dental Plan *CIGNA # 3215812* ☐ **DHMO** ☐ **PPO** **Eff. 1st of the mo. following hire**	**Employee Only** ☐	**Employee and Spouse** ☑	**Employee and Children** ☐	**Employee and Family** ☐	**Decline Dental Coverage** ☐	
Vision Plan *United Healthcare # A941* **Eff. 1st of the mo. following hire**	**Employee Only** ☐	**Employee and Spouse** ☐	**Employee and Children** ☐	**Employee and Family** ☐	**Decline Vision Coverage** ☐	
Supplemental Life Plan *UNUM* **(In addition to TCU paid Basic Life insurance). Eff. 1st of the mo. following hire**	**$25,000** ☐	**$50,000** ☐	**1X Salary** ☐	**2X Salary** ☐	**3X Salary** ☐	**4X Salary** ☐	**Decline Voluntary Life Coverage** ☐
Dependent Life Plan *UNUM* **(Employee must purchase Voluntary Life to purchase Dependent Coverage.) Eff. 1st of the mo. following hire**	**Spouse- up to 50% of Employee Voluntary Life (multiples of $5,000) Guaranteed Issue amount $50,000**				**Amount:**	**Decline** ☐
	Children- $10,000.00 per child at $.60 flat rate				**Amount:**	**Decline** ☐
Long-Term Disability *UNUM* **Eff. date of hire.**	**60%** ☐		**70%** ☐			**Decline LTD Coverage** ☐

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

Name (Last, First MI)	**Relationship**	**Social Security Number**	**Birthdate**	**Sex**	**Dentist's Name and ID Number** (Only if enrolled in DHMO)	**Dependent Life (□)**
						☐
						☐
						☐
						☐
						☐
						☐

Beneficiary Designation –MUST BE COMPLETED

Name (Last, First MI)	**Relationship**	**Social Security Number**	**Birthdate**	**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 coverage/s indicated above. I authorize TCU to adjust my paycheck by the required contribution for the selected coverage/s. 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**