

Notice of Personal Information

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.

**THE UNIVERSITY OF TEXAS SYSTEM
EMPLOYEE GROUP INSURANCE PROGRAM**

**CHANGE IN STATUS FORM FOR MID-YEAR BENEFIT ELECTION
CHANGES**

Treas. Reg. §1.125 prohibits changing your employee benefit elections mid-plan year (September 1 through August 31) unless one or more of the events described as a “Change in Status” has occurred. To make a change in your employee benefit elections outside of the usual Annual Enrollment period, you must meet one or more of the criteria listed below.

In addition, the change you request must be consistent with your qualified Change in Status event. If your requested change is not consistent with your Change in Status or your requested change does not fall within a category listed below, your request will be disapproved.

IMPORTANT: You have 31 days following the date of the qualifying event to submit this form to your campus benefits office. If this form is not received by your benefits office within 31 days, your request will be disapproved and you will have to wait until the next Annual Enrollment to apply to make the change. Evidence of Insurability (EOI) may be required.

SECTION I: CHANGE IN STATUS EVENTS AND COST OR COVERAGE CHANGES		DATE OF THE EVENT (mm/dd/yyyy)
Please check all that apply and provide the date of the event.		
<input type="checkbox"/>	Change in Your Marital Status due to marriage, divorce, annulment, legal separation, or spouse’s death	
<input type="checkbox"/>	Change in Number of Your Dependent Children due to birth, adoption, placement for adoption, death, or dependent child(ren)’s arrival to (or departure from) the United States	
<input type="checkbox"/>	Change in Residence that causes you, your spouse, or your dependent child(ren) to no longer be eligible for the plan originally selected	
<input type="checkbox"/>	Change in Employment Status such as changing from full-time to part-time employment, starting new employment, ending employment, returning from unpaid leave of absence, beginning your retirement, or other changes that affect plan eligibility (Note: To drop coverage, proof of other insurance enrollment must be provided.)	
<input type="checkbox"/>	Change in Dependent Eligibility such as marriage or divorce of your dependent child, or your dependent child attaining 25 years of age	
<input type="checkbox"/>	Cost Changes such as a mid-year increase (or decrease) in your benefit plan’s rates that causes you to have a significant increase (or decrease) in cost	
<input type="checkbox"/>	Coverage Changes: Significant Improvement or Curtailment of Benefit Package Option (With or Without Loss of Coverage) such as the addition of a new plan option, or the elimination or significant reduction of a plan benefit	
<input type="checkbox"/>	Change in Coverage Under Other Employer’s Plan such as a change in your spouse’s or dependent child’s benefits plan	
<input type="checkbox"/>	Loss of Coverage Under Certain Group Health Plans of Government or Educational Institutions such as a state children’s health insurance program (CHIP), state health benefits risk pool, or foreign government group health plan	
<input type="checkbox"/>	FMLA Leave If you are an employee taking leave under the Family and Medical Leave Act (FMLA), you may revoke an existing election and make other elections for the remaining portion of the coverage period under FMLA.	
<input type="checkbox"/>	COBRA Events such as your spouse or dependent child becoming eligible for continuation of coverage under a group health plan due to termination of your employment, divorce, legal separation, or dependent child reaching age 25	
<input type="checkbox"/>	Court Judgment, Decree, or Order from a legal separation, divorce, annulment, or change in custody that requires your dependent child to be covered under a group health plan	
<input type="checkbox"/>	Medicare or Medicaid Entitlement , such as you, your spouse or your dependent child with medical coverage becoming eligible (or losing eligibility) under Medicare or Medicaid. This change applies to all qualified benefits except the UT FLEX Day Care Reimbursement Account.	

SECTION II: BENEFIT PLAN CHANGES

Place a check mark beside each benefit change you request.

HEALTH BENEFITS	
<input type="checkbox"/> Add Dependent(s)	<input type="checkbox"/> Add Coverage
<input type="checkbox"/> Remove Dependent(s)	<input type="checkbox"/> Drop Coverage
	<input type="checkbox"/> Change Plan (if applicable)
LIFE INSURANCE AND/OR PERSONAL ACCIDENT INSURANCE	
<input type="checkbox"/> Add Dependent(s)	<input type="checkbox"/> Change Level of Coverage
<input type="checkbox"/> Remove Dependent(s)	<input type="checkbox"/> Change Amount of Coverage
	<input type="checkbox"/> Drop Coverage
	<input type="checkbox"/> Change Plan (if applicable)
DENTAL	
<input type="checkbox"/> Add Dependent(s)	<input type="checkbox"/> Add Coverage
<input type="checkbox"/> Remove Dependent(s)	<input type="checkbox"/> Drop Coverage
	<input type="checkbox"/> Change Plan (if applicable)
VISION	
<input type="checkbox"/> Add Dependent(s)	<input type="checkbox"/> Add Coverage
<input type="checkbox"/> Remove Dependent(s)	<input type="checkbox"/> Drop Coverage
SHORT TERM DISABILITY	
<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Drop Coverage
LONG TERM DISABILITY	
<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Drop Coverage
LONG TERM CARE	
<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Drop Coverage
UT FLEX	
<input type="checkbox"/> Medical Expense Reimbursement Account	<input type="checkbox"/> Day Care Reimbursement Account
<input type="checkbox"/> Change Election Amount	<input type="checkbox"/> Change Election Amount
<input type="checkbox"/> Cancel Election Amount	<input type="checkbox"/> Cancel Election Amount

IMPORTANT: I understand I will be required to provide the appropriate documentation for any of the changes I have requested above. I attest that the change requested is made as a result of and corresponds with the Change in Status event. Before I am allowed to drop coverage, I understand that I will be required to show proof of actual enrollment in a new outside plan. In addition, I am aware that completion of this form does not finalize my election change, and my benefits office will require that I complete an application form and additional forms, as needed, before my benefit changes are complete. I also understand that if my dependents were previously eligible under these plans, Evidence of Insurability (EOI) will be required.

_____	_____	____/____/____
Employee Signature	Print Name	MM / DD / YYYY
		(Date Signed)

____/____/____ MM / DD / YYYY Date Change In Status Form Received	<i>This Section for Benefits Office Use Only</i>	Approved _____ Declined _____
_____	_____	____/____/____
Benefits Office Signature	Print Name	MM / DD / YYYY
		(Date Signed)

Transitional Benefits

TRANSITIONAL BENEFITS SHOULD ONLY BE REQUESTED IF YOU ARE USING AN OUT OF-NETWORK PHYSICIAN

If you decide to change your health plan during Annual Enrollment and you are currently being treated for a chronic or ongoing medical condition, you may be eligible for Transitional Benefits. This means that, if your doctor is a contracting provider with your current health plan, but is not a contracting provider with Blue Cross and Blue Shield of Texas network of providers for UT SELECT or HMO Blue Texas, you may be allowed to continue seeing your current doctor for up to 3 months, and your claims will be paid at the In-Network benefit level.

Transitional Benefits gives you the opportunity to find a new Network provider while not risking the loss of medical care. Some medical conditions that are eligible for Transitional Benefits include:

- Pregnancy (if you are in your 3rd trimester on September 1)
- Cancer
- Allergy Treatments
- Organ Transplant
- Heart Failure
- Physical Therapy
- Behavioral Health Care
- Diabetes

Please complete the attached form and mail to the following address below for consideration. If you have any questions, please contact the appropriate Customer Service Numbers below.

MAIL TO:

Blue Cross and Blue Shield of Texas
Utilization Management
c/o Scottie Bradshaw, RN – Transitional Benefits
P.O. Box 833874
Richardson, TX 75083-3874
OR FAX TO: (866) 221-3607

CUSTOMER SERVICE:

UT SELECT
(866) 882-2034

HMO Blue Texas
(888) 322-2379

PRIVACY NOTICE: With a few exceptions, you are entitled to be informed about the information your University of Texas System institution collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review this information. Under Section 559.004 of the Texas Government Code you are entitled to have The University of Texas System institution correct information that is held by us and that is incorrect, in accordance with the procedures set forth in the University of Texas System Business Procedures Memorandum 32. The information that The University of Texas System institution 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.

THE UNIVERSITY OF TEXAS SYSTEM
Transitional Benefits Form

PATIENT INFORMATION

SUBSCRIBER NAME: _____ SSN: _____ INSTITUTION: _____

ADDRESS _____

INSURER: Blue Cross Blue Shield PPO HMOBlue

PATIENT NAME: _____ RELATIONSHIP: _____ HOME PHONE: _____

DOB: _____ WORK PHONE: _____

MEDICAL INFORMATION

PREGNANCY Estimated Due Date _____

SURGERY CURRENTLY SCHEDULED Type of Surgery _____ Date _____

HOME HEALTH SERVICES _____

TREATMENT OR THERAPY IN PROGRESS

Type of Treatment/Therapy _____

Do you have a Case Manager from your previous Health Plan?

Yes NAME _____ PLAN _____ PHONE _____

No

Do you have other insurance coverage?

Yes NAME _____ SUBSCRIBER ID # _____

No

PROVIDER INFORMATION

PHYSICIAN: _____ PHYSICIAN PHONE: _____

FACILITY: _____ FACILITY PHONE: _____

HMO MEMBERS ONLY:

Have you selected a Primary Care Physician?

Yes NAME _____

No

Thank you for your cooperation in completing the above information so that we may better assist you during this transition period.

PLEASE MAIL THIS FORM TO BCBSTX, Utilization Management, c/o Scott Bradshaw, R.N., PO Box 833874, Richardson, TX 75083