Southwestern Health Resources

Texas Health Resources® UTSouthwestern Medical Center®

2026 Benefit Election Form

Instructions
Complete all information below to make your benefit elections. Your benefit elections must be consistent with the allowed changes for your job or life event, as noted in your Employee Benefits Handbook. Enter an 'X' in the circle for each benefit option you want to elect. Fill in the dependent information for each dependent that you want to cover.

To view benefit information, including rates, visit **BeHealthySWHRCIN.org**.

Sign the last page and email to Texas Health Benefits Support at SWHRCINBenefitsSupport@texashealth.org prior to your enrollment deadline.

Employee ID # _____ Work Location _____

Employee Name _____

Employee Email Address _____

Employee Contact Phone Number _____ Employee Date of Birth _____

Event Date _____

- ◯ Marriage
- ◯ Birth
- ◯ Divorce
- ◯ Spouse/Child Gained Coverage
- ◯ Spouse/Child Lost Coverage
- ◯ Other _____
- ◯ New Hire
- ◯ Newly Eligible for Coverage

Dependents

List any dependents whose coverage is changing. Include each dependents SSN and Date of Birth to avoid delays. If adding a dependent for the first time, you are required to provide Dependent Verification.

DEPENDENT'S NAME: FIRST NAME, MIDDLE INITIAL AND LAST NAME	BIRTH DATE	SSN	RELATIONSHIP TO YOU**	GENDER	DISABLED

** Accepted Dependent Relationships are Spouse, Common Law Spouse, Child, Step-Child, Child via Court Order

Medical

	Employee Only	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
Quantum Care 750 Low Rx	◯	◯	◯	◯
Quantum Care 750 High Rx	◯	◯	◯	◯
UHC Choice 1000 Low Rx	◯	◯	◯	◯
UHC Choice 1000 High Rx	◯	◯	◯	◯
UHC Choice HDHP* Low Rx	◯	◯	◯	◯
UHC Choice HDHP* High Rx	◯	◯	◯	◯

*HDHP-High Deductible Health Plan Option

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	

◯ Waive All Medical Coverage for Yourself and Dependents

◯ No Changes - Keep this benefit the same

Health Savings Account

If you enroll in the UnitedHealthcare Choice HDHP option, you will receive a Health Savings Account (HSA) with money added each pay period, for a per pay period contribution of $19.23 for employee only coverage and $38.46 for family coverage. Enter the additional amount you would like contribute to the HSA, up to IRS limits*.

◯ Contribute an annual total of $_____ to the Health Savings Account

◯ Waive my contributions to the Health Savings Account (you do not have the option to waive the per pay period contribution that will be added to the HSA for you)

NOTE: Even if you do not make your own contributions to the Health Savings Account, by enrolling in the UnitedHealthcare Choice HDHP option, you agree to the terms and conditions listed at the bottom of this enrollment form.

Your total annual contribution will be divided by 26 pay periods if elections are made prior to January 1.
If your enrollment is completed after January 1, your annual contribution will be divided by the number of pay checks remaining in the year.

* The 2026 IRS limit is $4,400 for Employee Only coverage and $8,750 for Employee + Family coverage. If you are 55 or older, you may contribute an extra $1,000.

EMPLOYEE #

EMPLOYEE NAME

Dental

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Aetna DMO	○	○	○	○
Aetna PDN (Low Option)	○	○	○	○
Aetna PDN (High Option)	○	○	○	○

○ Waive All Dental Coverage for Yourself and Dependents

○ No Changes - Keep this benefit the same

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	

Vision

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Superior Vision by MetLife	○	○	○	○

○ Waive All Vision Coverage for Yourself and Dependents

○ No Changes - Keep this benefit the same

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Add Drop	
Add Drop	
Add Drop	
Add Drop	
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Add Drop	

Health Care Flexible Spending Account

○ Initial 2026 total annual contribution _____

○ Increase my 2026 annual contribution to _____

○ Decrease my 2026 annual contribution to _____

○ Waive Health Care Flexible Spending Account

○ No Changes - Keep this benefit the same

Day Care Flexible Spending Account

Regardless of the contribution you make to the Day Care Spending Account, the account comes with $23.08 per pay period. You will need to include this amount when deciding how much you want to contribute for the plan year and be sure the total amount (annual employer contribution and your contribution) do not exceed $5,000. To receive only the employer contribution, enter $0 as your contribution amount.

○ Initial 2026 total annual contribution _____

○ Increase my 2026 annual contribution to _____

○ Decrease my 2026 annual contribution to _____

○ Waive Day Care Flexible Spending Account

○ No Changes - Keep this benefit the same

Your total annual contribution will be divided by 26 pay periods if elections are made prior to January 1.
For enrollments completed after January 1, your annual contribution will be divided by the number of pay checks remaining in the year.

Additional Life

○ 1 x Salary

○ 2 x Salary

○ 3 x Salary

○ 4 x Salary

○ 5x Salary

○ 6 x Salary

○ Waive Additional Life Insurance for Yourself

○ No Changes - Keep this benefit the same

You may increase your life election only by 1 level when you have a life event.

You may decrease to any level.

Spouse Life

○ $10,000

○ $20,000

○ $30,000

○ $40,000

○ $50,000

○ $60,000 *

○ $70,000 *

○ $80,000 *

○ $90,000 *

○ $100,000 *

○ Waive Spouse Life

○ No Changes - Keep this benefit the same

*** Coverage over $50,000 is subject to evidence of insurability**

Child Life

○ $10,000

○ Waive Child Life

○ No Changes - Keep this benefit the same

Additional Accidental Death & Dismemberment (AD&D)

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Employee Only Coverage	Employee & Family Coverage
○ 1 x Annual Salary	○ 1 x Annual Salary
○ 2 x Annual Salary	○ 2 x Annual Salary
○ 3 x Annual Salary	○ 3 x Annual Salary
○ 4 x Annual Salary	○ 4 x Annual Salary
○ 5 x Annual Salary	○ 5 x Annual Salary
○ 6 x Annual Salary	○ 6 x Annual Salary
○ 7 x Annual Salary	○ 7 x Annual Salary
○ 8 x Annual Salary	○ 8 x Annual Salary
○ 9 x Annual Salary	○ 9 x Annual Salary
○ 10 x Annual Salary	○ 10 x Annual Salary

Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	

○ Waive Additional AD&D Coverage for Yourself and Dependents

○ No Changes - Keep this benefit the same

EMPLOYEE # _____ EMPLOYEE NAME _____

Short-Term Disability (STD)

- ◯ 14 Day Waiting Period
- ◯ 30 Day Waiting Period
- ◯ Waive Short-Term Disability Coverage
- ◯ No Changes- Keep this benefit the same

Long-Term Disability (LTD)

- ◯ Long-Term Disabilty Buy-up to 60%
- ◯ Waive Long-Term Disability 60% Buy-up Coverage
- ◯ No Changes - Keep this benefit the same

Voya Accident Insurance

	Employee Only	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
◯ Accident Insurance - Low	◯	◯	◯	◯
◯ Accident Insurance - High	◯	◯	◯	◯
◯ Waive Accident Insurance				
◯ No Changes - Keep this benefit the same				

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	

Voya Hospital Indemnity

	Employee Only	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
◯ Hospital Indemnity - Low	◯	◯	◯	◯
◯ Hospital Indemnity - High	◯	◯	◯	◯
◯ Waive Hospital Indemnity				
◯ No Changes - Keep this benefit the same				

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	

Voya Critical Illness-Employee

	$15,000 Coverage	***$30,000 Coverage***
◯ Critical Illness Employee	◯	◯
◯ Waive Critical Illness Employee		
◯ No Changes - Keep this benefit the same		

Voya Critical Illness-Dependent

	$15,000 Coverage	***$30,000 Coverage***
◯ Critical Illness Spouse	◯	◯
◯ Critical Illness Child(ren)	◯	◯
◯ Critical Illness Family	◯	◯
◯ Waive Critical Illness - Dependent		
◯ No Changes - Keep this benefit the same		

List the name of each **Dependent** you are changing. Circle **Add** or **Drop** clearly.

Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	
Add Drop	

Please note that you must elect coverage for yourself in order to elect coverage for a dependent(s).
You cannot elect a higher coverage level for yourself than you have for your dependent(s).

Legal Insurance

- ◯ Legal Insurance
- ◯ Waive Legal Plan
- ◯ No Changes - Keep this benefit the same

ID Protection

- ◯ Employee Only
- ◯ Employee + Family
- ◯ Waive ID Protection
- ◯ No Changes - Keep this benefit the same

EMPLOYEE #

EMPLOYEE NAME

Authorization

By signing or typing my name below, I indicate that I have read my enrollment guide and other materials and understand the options available to me. I authorize payroll deductions for my share of the cost of my benefits for 2026 and understand that any before-tax deductions may slightly reduce my Social Security retirement benefits. I understand that I cannot change my benefit elections during the year unless I have a status change or qualify for special enrollment rights.

If enrolling in the Health Care and/or Dependent Care Flexible Spending Account or in Life or Disability Coverage:

I understand that I must request reimbursement of eligible expenses by March 31, 2026. I understand that as a flexible spending account participant, I may be required to provide additional documentation for certain Flex Debit Card transactions. I further understand that if I elected to increase my life or disability coverage, the increases will not become effective until I return from leave.

If enrolling in the Health Savings Account:

By enrolling in this Health Savings Account plan, you are certifying that you meet all qualifications to contribute your elected amount and that you are responsible for any penalties incurred based on illegal or excess contributions.

By entering an HSA contribution amount and selecting Save and Continue below, I confirm the following:

- I wish to establish and/or continue an HSA with HealthEquity as custodian
- I'm eligible to contribute to an HSA because none the following applies to me:
  - I am not covered by Medicare or TRICARE
  - I'm not covered by any other non-high deductible health plan (i.e., a plan with a deductible less than $1,700 for individuals and $3,400 for families, based on 2026 limits)
  - I won't receive medical reimbursement from someone else's general-purpose Flexible Spending Account
  - I won't be claimed as a dependent on someone else's tax return
- I accept the terms of the HealthEquity HSA Custodial Agreement available at **BeHealthySWHRCIN.org/Health-Savings-Account** before submitting your elections. I understand that in compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all individuals who seek to open an HSA. I understand that as part of this identity verification process, I may be asked to provide additional information and/or documentation before my account can be established.

I certify that the information I have given in connection with this enrollment is true and complete. I understand that if I have not given true and complete information, that I may be disciplined or terminated, the coverage for me and my dependents may be terminated, and I will be responsible for all expenses in connection with my misrepresentations. I understand that costs are estimated based on the personal information I entered, and that the actual deduction may be different if the personal information provided was not correct.

EMPLOYEE SIGNATURE

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