HR 112 (9/2025)

System Member ____

The Texas A&M University System

Survivor Medical/Dental/Vision Continuation Form

With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form.

* S C F *

Survivor's Name (last, first, middle initial)	*Survivor's Date of Birth*	*Survivor's UIN*
Survivor's Social Security Number	*Survivor's Gender*	
Deceased's Name (last, first, middle initial)	*Deceased's Date of Death*	*Deceased's UIN*

In the event of the death of a Texas A&M University System employee or retiree, a surviving spouse and/or surviving children who meets the eligibility requirements can continue health, dental and/or vision coverage. Eligibility requirements are outlined in the Employee Benefit Guide and the Retiree Benefit Guide. Dependents not covered at the time of the employee's/retiree's death cannot be added to coverage. Survivors are not eligible to receive the employer contribution toward premiums. ***Once survivors and/or any dependents cancel coverage, coverage cannot be reinstated.***

A survivor who meets the eligibility requirements has **60 days from the date of death to continue coverage**. A survivor who does not meet the eligibility requirements can continue coverage through COBRA and should contact the deceased's Human Resources/Benefits office.

If you are age 65 or older, or otherwise eligible for Medicare, you will need to enroll in Medicare if you are not already enrolled. It is very important for you and any other covered Medicare-eligible dependents to enroll in both Parts A and B of Medicare. Unless you are working and have insurance at your place of employment, Medicare will become your primary carrier. A copy of your Medicare card must be provided to the Human Resources/Benefits Office.

I am a survivor of a (*please check one*): ☐ **Retiree** ☐ **Employee**

Have you used tobacco products within the last 3 months? ☐ **Yes** ☐ **No**

Please select the coverage(s) you would like to continue - Medical, Dental and/or Vision:

Medical - select your current plan: _____

Dental - select your current plan: _____

Vision – select your current plan: _____

If cancelling coverage, please select which coverage(s) you are cancelling (*changes are effective the first of the month after this form is received*):

☐ Medical

☐ Dental

☐ Vision

Date Stamp

HR112 Survivor's UIN: _____

Dependent Children Information

To continue coverage for currently enrolled dependent children or to drop dependent(s) from coverage, complete the following and indicate **KEEP** or **DROP** for each coverage you wish to continue or change for each dependent (list additional dependents on a separate page).

Dependent Child's Name	Social Security Number	Birthdate (MM/DD/YYYY)	Relationship	Medical *Keep/Drop*	Dental *Keep/Drop*	Vision *Keep/Drop*

2025-2026 Survivor Monthly Premiums

If you have questions about billing, contact the former employee's/retiree's Human Resources/Benefits office.

	Survivor Only	**Survivor & Child(ren)**
A&M Care Plan	$1,045.06	$1447.30
65 Plus Medicare Advantage Plan (PPO)	$352.47	$704.93
A&M Dental Plan (PPO)	$32.02	$67.22
DeltaCare USA Dental HMO	$21.72	$38.90
Superior Vision by MetLife	$8.36	$13.70

Billing Agreement:

I authorize The Texas A&M University System to bill me or draft my bank account on a monthly basis to cover my share of the premiums for the coverages I have elected. I understand that failure to pay my premium(s) will result in cancellation of coverage. Furthermore, I understand that if my coverage is cancelled for any reason, I will not be able to reinstate this coverage at a later date.

_____ _____

Name *Email Address*

_____ _____

Telephone Number *Street Address*

_____ _____ _____

City *State* *Zip code*

_____ _____

Signature in ink (blue ink preferred) *Signature Date (MM/DD/YYYY)*