

ARLINGTON ISD BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE _____

PERSONAL INFORMATION				
Employee Last Name	First Name	SSN	Emp ID #	
Address		City	State	ZIP Code
Home Phone	Date of Birth	Pay Period:	<input type="checkbox"/> 12 Pay	<input type="checkbox"/> 18 Pay <input type="checkbox"/> 26 Pay

COVERED FAMILY MEMBERS INFORMATION				
If adding a qualified family member, you must complete all family member information requested. If changing coverage, only list the member(s) with the qualified change.				
Spouse Last Name	First Name	Date Of Birth	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female
Childs Last Name	First Name	Date Of Birth	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female
Childs Last Name	First Name	Date Of Birth	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female
Childs Last Name	First Name	Date Of Birth	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female

REASON FOR REQUEST/QUALIFIED EVENT	
You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Benefits Department within 31 days of the change. Proof of change is required. Your request will be denied if you fail to notify the Benefits Office within 31 days. Complete "Covered Family Members" section with the names of family members to be added or canceled.	
<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption of a child/Gains legal guardianship <input type="checkbox"/> Death of spouse or dependent <input type="checkbox"/> Dependent becomes eligible	<input type="checkbox"/> Dependent becomes ineligible <input type="checkbox"/> Loss of other qualified group coverage <input type="checkbox"/> Spouse changes employment-Gains Coverage <input type="checkbox"/> Spouse changes employment-Loses Coverage <input type="checkbox"/> Other -Explain _____

COVERAGE

Complete chart with changes relative to the reason form request/qualified event

<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change			
WELLNESS PROGRAM: I choose to participate in the Employee Wellness Program <input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>MEDICAL</u> <input type="checkbox"/> Plan 1-HD <input type="checkbox"/> Plan 2 <input type="checkbox"/> Select Plan <input type="checkbox"/> Scott & White HMO <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Employee + Family	<u>DENTAL</u> <input type="checkbox"/> High PPO <input type="checkbox"/> Low PPO <input type="checkbox"/> DHMO <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Employee + Family	<u>VISION</u> <input type="checkbox"/> Vision <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Employee + Family	<u>MEDLINK MEDICAL GAP PLAN</u> <input type="checkbox"/> Medlink Medical Gap Plan <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Employee + Family

<u>HEALTHCARE SAVINGS ACCOUNT</u> Monthly Amount: _____ \$3,350 Annual Individual Maximum \$6,750 Annual Maximum <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee	<u>TELE-HEALTH</u> <input type="checkbox"/> MDLIVE <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family	<u>CANCER</u> <input type="checkbox"/> High Option Basic Plan <input type="checkbox"/> High Option + ICU Rider <input type="checkbox"/> Low Option Basic Plan <input type="checkbox"/> Low Option + ICU Rider <u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Children <input type="checkbox"/> Employee + Family
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<u>DISABILITY</u> Waiting Period: _____ Coverage Amount: _____	<u>GROUP LIFE</u> Employee Coverage Amount: _____ Spouse Coverage Amount: _____ Child Coverage Amount: _____	<u>MEDICAL REIMBURSEMENT</u> Monthly Amount: _____ \$2,550 Annual Maximum
<u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee	<u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee

<u>DEPENDENT CARE REIMBURSEMENT</u> Monthly Amount: _____ \$5,000 Annual Maximum	<u>IDENTITY THEFT PROTECTION</u> <input type="checkbox"/> ID Watchdog Plus <input type="checkbox"/> ID Watchdog Platinum	<u>LEGAL SERVICES</u> <input type="checkbox"/> Metlaw Hyatt Legal Plan
<u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee	<u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<u>LEVEL OF COVERAGE</u> <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family

I have reviewed and understand the benefit plans and rates located on the Benefits website (www.myaisdbenefits.net). I authorize any payroll deductions required for the benefit selections I have made on this form. I also understand that the above selections may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I also understand that changes resulting in the addition of coverage will be effective the 1st day of the month following the qualifying event. I will be responsible for paying back any missed premiums. If dropping coverage, the effective date will be the 1st of the month following the signature date.

Signature _____

Date _____

Please email the completed for to hrcbenefits@aisd.net or fax to 682-867-4651

FOR BENEFITS DEPARTMENT USE		
<input type="checkbox"/> ACCEPT <input type="checkbox"/> DENIED	Date Received	Date Entered in Benefits Hub