BENEFIT CHANGE FORM

Complete and return this form to the Benefits Dept. within 31 days of a status change.

Employee Information

Legal First Name ______ MI ___ (i.e. Elizabeth)

Legal Last Name ______ (i.e. Smith)

Social Security Number ______

Date of Birth ______ (i.e. 01/01/1970)

M / F ______

Home Address ______

City ______

State ______

Zip Code ______

Home / Cell Preferred Phone Number ( ) ______

Work Phone Number ( ) ______ Ext. ______

Email Address ______

Alternate Email Address ______

Change in Family Status

Instructions: Place your initials in the box for the status change you have experienced since the beginning of the current plan year with the date of the status change:

Status	Initials	Date
Marriage	☐	Date ______
Divorce	☐	Date ______
Birth or Adoption	☐	Date ______
Reduction of Hours	☐	Date ______
Change in Job of Spouse	☐	Date ______
Death	☐	Date ______
Other	☐	Date ______

Dependent To Add or Drop

Dependent Name ______

Social Security Number ______

Date of Birth ______ M / F ______

Relationship ______

Dependent Name ______

Social Security Number ______

Date of Birth ______ M / F ______

Relationship ______

Dependent Name ______

Social Security Number ______

Date of Birth ______ M / F ______

Relationship ______

Dependent Name ______

Social Security Number ______

Date of Birth ______ M / F ______

Relationship ______

Payroll Information

For Employee Benefits Department Use Only

New Coverage Effective Date ______

Payroll Effective Date ______

Pay Frequency ______

I hereby certify that the above information is true and correct to the best of my knowledge and that evidence of the above events must be submitted to the Plan Administrator. I understand that Change in Family Status is subject to validation and approval of Administrator.

Employee Signature ______ Date Signed ______

Benefit Administrator Signature ______ Date Signed ______

BENEFIT CHANGES

FIRST NAME: **LAST NAME:**

Instructions: Place your initials in the box for the plan you wish to elect.

All Pre -Tax changes must correspond to a status change.

TRS MEDICAL COVERAGE

Select Your Plan		Select Your Coverage Category			
ActiveCare HD	☐	Employee Only	☐	Split Premium (Spouse with another TRS Health District)	☐
ActiveCare 2	☐	Employee + Spouse	☐	Pool Premium (FWISD Spouse)	☐
ActiveCare Primary (Requires PCP #*)	☐	Employee + Child(ren)	☐	*PCP #: HO____________________	
ActiveCare Primary + (Requires PCP #*)	☐	Employee + Family	☐	***Decline Medical***	☐
Central & North Texas Baylor Scott & White HMO	☐				

UNITED CONCORDIA DENTAL

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

HUMANA ADVANTAGE PLUS DENTAL

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

HUMANA DHMO DENTAL

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Decline Dental ☐

HUMANA VISION COVERAGE

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Decline Vision ☐

THE HARTFORD DISABILITY PROTECTION

Elimination Period
- 14 Days ☐
- 30 Days ☐
- 45 Days ☐
- 90 Days ☐

Monthly Benefit Amount $___________

Benefit Duration
- 5 Years ☐
- SSNRA* ☐

Cancel / Decline Disability ☐

Please Note: Cancelling Life or Disability coverage will make you and/or your Dependents subject to underwriting guide-lines and possible denial if you apply for coverage in FWISD in the future.

* SSNRA is the Social Security Normal Retirement Age

AMERICAN PUBLIC LIFE CANCER

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline Cancer ☐

FLEXIBLE SPENDING ACCOUNTS

	Annual Limit
Per Pay Day Medical Amount ______________	$ 2,850
Per Pay Day Dependent Care Amount ______________	$ 5,000

Decline Reimbursement Accounts ☐

HEALTH SAVINGS ACCOUNT

	Annual Limit
Per Pay Day Employee Amount ______________	$ 3,650
Per Pay Day Family Amount ______________	$ 7,300
Annual 55+ Catch-up Amount ______________	

Cancel / Decline H.S.A ☐

* OPTIONAL LIFE AND AD&D

Employee Coverage Amount $______________

Cancel / Decline Employee Life ☐

* OPTIONAL DEPENDENT LIFE

Employee Coverage required to cover Dependents

	Amount	
Optional Spouse Life	$__________	☐
Optional Child Life	$__________	☐

Cancel / Decline Spouse Life ☐

Cancel / Decline Child Life ☐

CHUBB ACCIDENT GOLD PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline Accident ☐

CHUBB ACCIDENT DIAMOND PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline Accident ☐

MASA EMERGENT PLUS PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline MASA ☐

MASA PLATINUM PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline MASA ☐