GRAPEVINE COLLEYVILLE INDEPENDENT SCHOOL DISTRICT

BENEFIT CHANGE FORM 2023-24

You may add or cancel coverage during the Plan Year if you have a change in family status and notify GCISD Benefits office within 30 days of change. Complete and return this form along with documentation of change.

www.gcisdbenefits.com

FBS
A Higginbotham Partner

Employee Information

Legal First Name _____ MI ____ (i.e. Elizabeth)

Legal Last Name _____ (i.e. Smith)

Last 4 of Social Security _____

M / F _____

Home Address _____

City _____ State _____ Zip Code _____

Home / Cell Preferred Phone Number ( ) _____

Work Phone Number ( ) _____ Ext. _____

Primary Email Address _____

Alternate Email Address _____

Change in Family Status

Please check the box for the type of change and provide the date of change.

- *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 (If adding dependent, log into benefits portal and also add to your dependent page.)

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. I understand 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 Reviewed | Approved or Declined

2023-24 PlanYear Benefit Changes

Instructions: Place check boxes for only plans you wish to change.

First Name: _____ **Last Name:** _____

UBC– Alliance

Select Your Plan		Select Your Coverage Category			
Value HD	☐	Employee Only	☐	Pooled Premium (GCISD Spouse)	☐
Basic HD (HSA compatible)	☐	Employee + Spouse	☐		
Standard	☐	Employee + Child(ren)	☐		
Enhanced	☐	Employee + Family	☐	***Decline Medical***	☐

The Hartford Hospital Indemnity

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

Option 1/$500 HIP ☐
Option 2/$1000 HIP ☐
Option 3/$2000 HIP ☐
Cancel / Decline HIP ☐

Cigna Dental

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

High Plan Dental ☐
Low Plan Dental ☐
Cancel / Decline Dental ☐

QCD Discount dental

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

Cancel / Decline Discount Dental ☐

Superior Vison

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

Cancel / Decline Vision ☐

The Hartford Disability Protection

Elimination Period

- 7 Days ☐
- 14 Days ☐
- 30 Days ☐
- 60 Days ☐
- 90 Days ☐
- 180 Days ☐

Note: Changes to Disability coverage will result in new pre-existing limitations.

Monthly Benefit Amount _____

Cancel / Decline Disability ☐

APL Cancer

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

High Plan Cancer ☐
High Plan w/ICU Rider Cancer ☐
Low Plan Cancer ☐
Low Plan w/ICU Rider Cancer ☐
Cancel / Decline Cancer ☐

The Hartford Accident

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

High Plan Accident ☐
Low Plan Accident ☐
Cancel / Decline Accident ☐

Unum Voluntary Life

- Employee Coverage $ _____
- Spouse Coverage $ _____
- Child(ren) Coverage $ _____

Cancel / Decline Employee Life ☐
Cancel / Decline Spouse Life ☐
Cancel / Decline Child(ren) Life ☐

UNUM AD&D Life

- Employee Coverage $ _____
- Family Coverage $ _____

Cancel / Decline AD&D ☐

Health Savings Account

	Annual Limit
Monthly Employee Amount _____	$ 3,850
Monthly Family Amount _____	$ 7,3750
Monthly 55+ Catchup _____	

Cancel / Decline HSA ☐

Flexible Spending Accounts

	Annual Limit
FSA Monthly Deduction: _____	$ 3,050
Dependent Care Monthly _____	$ 5,000

Cancel / Decline Reimbursement ☐

NOTE: Employee Life required for Spouse/Child. Evidence of insurability maybe required to change life election's or to reinstate if cancelled. Be sure to log in and designate beneficiary.