



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 _____	Legal Last Name _____	Social Security Number _____	Date of Birth _____	M / F _____
(i.e. Elizabeth)	(i.e. Smith)		(i.e. 01/01/1970)	
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:

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

New Coverage Effective Date _____	Payroll Effective Date _____	Pay Frequency _____
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For Employee Benefits Department Use Only

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-ActiveCare MEDICAL COVERAGE			
Select Your Plan		Select Your Coverage Category	
ActiveCare HD	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>
ActiveCare 2	<input type="checkbox"/>	Employee + Spouse	<input type="checkbox"/>
ActiveCare Primary (Requires PCP #*)	<input type="checkbox"/>	Employee + Child(ren)	<input type="checkbox"/>
ActiveCare Primary + (Requires PCP #*)	<input type="checkbox"/>	Employee + Family	<input type="checkbox"/>
		Split Premium (Spouse with another TRS Health District)	<input type="checkbox"/>
		Pool Premium (FWISD Spouse)	<input type="checkbox"/>
		*PCP #: HO _____	
		Cancel / Decline Medical	<input type="checkbox"/>

METLIFE INDEMNITY DPPO DENTAL	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>

HUMANA ADVANTAGE PLUS DENTAL	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>

HUMANA DHMO DENTAL	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline Dental	<input type="checkbox"/>

HUMANA VISION COVERAGE	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline Vision	<input type="checkbox"/>

THE HARTFORD DISABILITY PROTECTION		
<u>Elimination Period</u>	<u>Benefit Duration</u>	Please Note: Cancelling Life or Disability coverage will make you and/or your Dependents subject to underwriting guidelines and possible denial if you apply for coverage in FWISD in the future.
14 Days <input type="checkbox"/>	5 Years <input type="checkbox"/>	
30 Days <input type="checkbox"/>	SSNRA* <input type="checkbox"/>	
45 Days <input type="checkbox"/>	Cancel / Decline Disability <input type="checkbox"/>	
90 Days <input type="checkbox"/>		
Monthly Benefit Amount \$ _____		

AMERICAN PUBLIC LIFE CANCER	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline Cancer	<input type="checkbox"/>

* SSNRA is the Social Security Normal Retirement Age

FLEXIBLE SPENDING ACCOUNTS	
Per Pay Day Medical Amount	Annual Limit
_____	\$ 3,200
Per Pay Day Dependent Care Amount	_____
_____	\$ 5,000
Cancel / Decline Reimbursement Acct.	<input type="checkbox"/>

HEALTH SAVINGS ACCOUNT	
Per Pay Day Employee Amount	Annual Limit
_____	\$ 4,150
Per Pay Day Family Amount	_____
_____	\$ 8,300
Annual 55+ Catch-up Amount	_____
_____	\$ 1,000
Cancel / Decline HSA	<input type="checkbox"/>

* OPTIONAL LIFE AND AD&D	
Employee Coverage Amount	\$ _____
Cancel / Decline Employee Life	<input type="checkbox"/>

* OPTIONAL DEPENDENT LIFE	
<u>Employee Coverage required to cover Dependents</u>	
	Amount
Optional Spouse Life	\$ _____ <input type="checkbox"/>
Optional Child Life	\$ _____ <input type="checkbox"/>
Cancel / Decline Spouse Life	<input type="checkbox"/>
Cancel / Decline Child Life	<input type="checkbox"/>

CHUBB ACCIDENT GOLD PLAN	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline Accident	<input type="checkbox"/>

CHUBB ACCIDENT DIAMOND PLAN	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline Accident	<input type="checkbox"/>

MASA EMERGENT PLUS PLAN	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline MASA	<input type="checkbox"/>

MASA PLATINUM PLAN	
Employee Only	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>
Cancel / Decline MASA	<input type="checkbox"/>