ESC20/DIVISION NAME:_____ 2013-2014 Election Form

Please print clearly and copy, scan, and email to Jessica Thierry at jessicat@fbsbenefits.com or fax @ (469)385-4641

New Hire Enrollment ☐ Qualifying Event ☐ Termination ☐ Information Update ☐

1.Employee Information **All employee information is required for enrollment*

Legal Name _____ Address _____

Date of Birth _____ City/State/Zip _____

Social Security Number _____ Home Phone _____

Gender _____ Email _____

2. Employment Information **All employment information is required for enrollment*

Date of Hire _____ Hours Per Week _____

Annual Salary _____ Effective Date _____

Pay Frequency _____

3. Qualifying Event Change **Please attach proof and documentation (marriage certificate, letter of credible coverage, etc.)*

Qualifying Event Type _____

Effective Date _____

4. Termination Request

Termination Date _____

Benefit Term. Date _____

5. Section 125 Plan Participation

Yes ☐

No ☐

6. Dependent Information

Spouse _____ Child _____

Date of Birth _____ Date of Birth _____

Social Security Number _____ Social Security Number _____

Gender _____ Gender _____

Child _____ Child _____

Date of Birth _____ Date of Birth _____

Social Security Number _____ Social Security Number _____

Gender _____ Gender _____

Benefit Enrollment/Changes	**First Name:**	**Last Name:**

***Basic Life**

Employee Only Coverage ☐

**Designate Beneficiaries Below*

TRS Medical Coverage and Medlink

**Please see your Benefit Administrator to Elect Medical Coverage

MedLink (Helps to offset out of pocket health expenses)

Plan/Premium:

Waive MedLink ☐

***Cigna Voluntary AD&D**

Employee Coverage $

Family Coverage $

Waive AD&D ☐

***Cigna Voluntary Life**

Employee Coverage	$	Monthly Premium	$
Spouse Coverage	$	Monthly Premium	$
Child(ren) Coverage	$	Monthly Premium	$

Waive Vol. Life ☐

**Designate Beneficiaries Below*

Cigna High Option Dental

Employee Only	$23.62	☐
Employee+Spouse	$59.10	☐
Employee+Children	$64.82	☐
Employee+Family	$90.36	☐

Waive Discount Dental ☐

Cigna Low Option Dental

Employee Only	$12.54	☐
Employee+Spouse	$23.68	☐
Employee+Children	$26.30	☐
Employee+Family	$40.80	☐

Waive Co-pay Dental ☐

Cigna DHMO Dental

Employee Only	$8.99	☐
Employee+Spouse	$16.99	☐
Employee+Children	$19.15	☐
Employee+Family	$29.66	☐

Waive Indemnity Dental ☐

APL Accident

Employee Only	$10.80	☐
Employee+Spouse	$19.40	☐
Employee+Children	$21.20	☐
Employee+Family	$29.80	☐

Waive Accident ☐

Disability

Elimination Period

Monthly Benefit $

Monthly Premium $

Short Term/Long Term

Waive Disability ☐

Superior Vision

Employee Only	$6.88	☐
Employee+Spouse	$13.66	☐
Employee+Children	$13.38	☐
Employee+Family	$20.36	☐

Waive Vision ☐

APL Cancer Low Option

Employee Only	$14.80	☐
Employee+Children	$20.60	☐
Employee+Family	$26.40	☐

Waive Cancer Option ☐

APL Cancer Low Option w/ICU

Employee Only	$17.80	☐
Employee+Children	$24.80	☐
Employee+Family	$32.70	☐

Waive Cancer Option ☐

APL Cancer High Option

Employee Only	$29.40	☐
Employee+Children	$40.40	☐
Employee+Family	$51.50	☐

Waive Cancer Option ☐

APL Cancer High Option w/ICU

Employee Only	$32.40	☐
Employee+Children	$44.60	☐
Employee+Family	$57.80	☐

Waive Cancer Option ☐

Reimbursement Accounts

Medical Reimbursement

Annual Amount $

Waive Medical Reimburs. ☐

Dependent Care Reimbursement

Annual Amount $

Waive Dependent Care ☐

~ACS/BNY Mellon HSA

Annual Amount $

~AVAILABLE W/AC 1HD *Waive* ☐

ID Watchdog ID Theft Protection

PLUS Individual	$7.95	☐
PLUS Family	$14.95	☐

Waive ID Theft ☐

***PRIMARY BENEFICIARIES**

Name

Relationship

Percentage

Name

Relationship

Percentage

***CONTINGENT BENEFICIARIES**

Name

Relationship

Percentage

Name

Relationship

Percentage

I understand that I have verified the benefit selections I have made and authorize any payroll deductions required for those selections.

I also understand that any qualifying event change will not be made without proper documentation.

Employee Signature _____ Administrator Signature _____

Date _____ Date _____