

## CHECKLIST FOR COMPLETING A QUALIFIED LIFE EVENT FORM

All Life Events must be reported within 31 days of your Life Event Effective Date.

Please follow this checklist to ensure the form is completed accurately.

<input type="checkbox"/> Employee Name	<input type="checkbox"/> Wellness	<input type="checkbox"/> Disability Election
<input type="checkbox"/> Employee SSN	<input type="checkbox"/> Tele-health Election	<input type="checkbox"/> Group Life Election - Employee
<input type="checkbox"/> Employee ID Number	<input type="checkbox"/> Hospital Indemnity Election	<input type="checkbox"/> Group Life Election - Spouse
<input type="checkbox"/> Daytime Telephone Number	<input type="checkbox"/> Dental Election	<input type="checkbox"/> Group Life Election - Child
<input type="checkbox"/> Qualifying Event Date	<input type="checkbox"/> Vision Election	<input type="checkbox"/> AD&D Election
<input type="checkbox"/> Life Event Reason (indicate only one reason)	<input type="checkbox"/> Cancer Election	<input type="checkbox"/> Healthcare Savings (HSA) Election
<input type="checkbox"/> Required Dependent Information (only complete for the dependents you are adding/removing from coverage)	<input type="checkbox"/> Identity Theft Protection Election	<input type="checkbox"/> Medical Reimbursement (FSA) Election
<input type="checkbox"/> Medical Election	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Dependent Care Reimbursement Election

## EXAMPLES OF VALID SUPPORTING DOCUMENTATION

Life Event	Documentation Example
Marriage	Copy of Marriage Certificate
Divorce	Court Documents (must include Judges signature and the effective date of the divorce)
Birth/Adoption/Legal Custody of Child	Birth Certificate, Crib Card, Hospital discharge paperwork (must provide newborn's name and date of birth), or Court Documents (must include the effective date of the custody of child)
Death of Spouse/Child	Copy of Death Certificate
Gain of Spouse Employment/Coverage	Letter from employer or carrier(s) listing the dependent's name, the type of coverage(s) gained and the effective date of coverage(s)
Loss of Spouse Employment/Coverage	HIPAA Certificate, or letter from employer or carrier(s) listing the dependent's name, the type of coverage(s) lost and the effective date of the terminated coverage)
Gain of Medicare Coverage	Medicare Award letter, or copy of Medicare ID card (must include effective date)
Gain of Medicaid Coverage	Medicaid Award letter (must include effective date)
Dependent Now Ineligible	Letter from Employee

**All changes to benefits are effective the 1st of the month following the date of the event, unless the date of the event falls on the 1st of the month. In that case the benefits are effective that day. Newborns' benefits are effective as of the date of birth.**

**All correspondence from employers, carriers, and/or colleges/institutions must be provided on respective letterhead.**



# Insurance Change Form

You may add or cancel coverage during the Plan Year. If you have a Qualifying Life Event, it is ***your responsibility*** to complete this form and send it to the email address below within **31 days** of the qualifying event. Otherwise, you will NOT be able to change your benefits until the next annual enrollment period. This form must be accompanied by appropriate documentation (i.e. marriage/death/birth or hospital certificate, etc.), which reflect the effective date of the qualifying event. Payroll increases/decreases will be reflected when approved

*Please keep a copy of the complete forms for your files.*

## Personal Information

Employee Name	Employee SSN
Employee ID Number	Daytime Telephone Number
Qualifying Event Date	

## REQUIRED DEPENDENT INFORMATION *(Only add the dependent you are adding/removing from coverage)*

Name (Last, First)	SSN	Date of Birth	Gender	Relation (S=Spouse, C=Child, H=Handicapped)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Life Event Reason

### ADDITIONS/DOCUMENTATION NEEDED

- Marriage: Marriage Certificate
- Divorce: Divorce Decree
- Birth: Certificate of Birth or Hospital Certificate
- Adoption: Placement of Papers of Adoption
- Loss of Spouse Employment: Letter from employer or carrier
- Death of Spouse: Death Certificate

### DELETIONS/DOCUMENTATION NEEDED

- Marriage: Marriage Certificate
- Divorce: Divorce Decree
- Gain of Spouse Employment: Letter from employer or carrier
- Dependent Now Ineligible: Letter from Employee
- Medicare Entitlement: Medicare Letter/copy of Medicare ID card
- Medicaid Entitlement: Medicaid Award letter
- Death of Child: Death Certificate
- Death of Spouse: Death Certificate



# Insurance Change Form

**Coverage** (Please mark the Plan and Coverage Level you are electing as a result of this Qualifying Life Event)

## MEDICAL

Plan:  ActiveCare 1-HD  ActiveCare 2 (can only be elected if previously enrolled prior to 9/1/2020)  ActiveCare Select  Scott & White HMO

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## WELLNESS

YES  NO

## TELE-HEALTH

Plan:  MDLive

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## HOSPITAL INDEMNITY

Plan:  Hospital Indemnity

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## DENTAL

Plan:  High PPO  Low PPO  DHMO

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## VISION

Plan:  Davis Vision

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## CANCER

Plan:  High Option Basic Plan  High Option + ICU Rider  Low Option Basic Plan  Low Option + ICU Rider

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## IDENTITY THEFT PROTECTION

Plan:  1 Bureau

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## LEGAL SERVICES

Plan:  Metlaw Legal Plan

Coverage Level:  Waive  Employee Only  Employee + Spouse  Employee + Child(ren)  Family

## DISABILITY

Waiting Period:  14 Day  30 Day  60 Day  90 Day

Coverage Level:  30% of Salary  40% of Salary  50% of Salary  60% of Salary

## GROUP LIFE - EMPLOYEE

Coverage Level:  Waive  (Can elect in increments of \$10,000 up to maximum of 7 x's salary or \$500,000)

## GROUP LIFE - SPOUSE

Coverage Level:  Waive  (Can elect in increments of \$5,000 up to maximum of \$100,000)

## GROUP LIFE - CHILD

Coverage Level:  Waive  (Can elect in increments of \$1,000 up to maximum of \$10,000)

## ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

### EMPLOYEE

Coverage Level:  Waive  (Can elect in increments of \$10,000 up to maximum of 10 x's salary or \$500,000)



# Insurance Change Form

**FAMILY**

Coverage Level:  Waive

Can elect in increments of \$10,000 up to maximum of 10 x's salary or \$500,000

**HEALTHCARE SAVINGS ACCOUNT (HSA)**

Coverage Level:  Waive

(Can elect a minimum \$25.00 monthly amount up to a maximum \$295.83 individual monthly amount or a maximum \$591.67 family monthly amount)

**MEDICAL REIMBURSEMENT ACCOUNT (FSA)**

Coverage Level:  Waive

(Can elect a minimum \$25.00 monthly amount up to a maximum \$229.17 individual monthly amount or a maximum \$458.33 family monthly amount)

**DEPENDENT CARE REIMBURSEMENT ACCOUNT**

Coverage Level:  Waive

(Can elect a minimum \$25.00 monthly amount up to a maximum \$416.67 monthly amount)

Employee Name

Employee ID

Employee Signature

Date

Please return completed form, along with appropriate documentation to [hrcbenefits@aisd.net](mailto:hrcbenefits@aisd.net) or 682-867-4651 (fax)

**TRS Medical Rates**

**2019-2020 TRS ActiveCare Health Insurance Premiums Without Wellness Program Incentive**

<b>12 Pay—Administrators and Professionals</b>				
	<b>TRS ActiveCare 1-HD</b>	<b>TRS ActiveCare 2</b>	<b>TRS ActiveCare Select</b>	<b>Scott &amp; White HMO</b>
Employee Only	\$143.00	\$617.00	\$321.00	\$323.54
Employee + Children	\$487.00	\$1,032.00	\$667.00	\$641.76
Employee + Spouse	\$831.00	\$1,785.00	\$1,132.00	\$1,071.58
Family	\$1,180.00	\$2,154.00	\$1,483.00	\$1,222.28
<b>12 Pay—Para-Professionals</b>				
	<b>TRS ActiveCare 1-HD</b>	<b>TRS ActiveCare 2</b>	<b>TRS ActiveCare Select</b>	<b>Scott &amp; White HMO</b>
Employee Only	\$128.00	\$602.00	\$306.00	\$308.54
Employee + Children	\$472.00	\$1,017.00	\$652.00	\$626.76
Employee + Spouse	\$816.00	\$1,770.00	\$1,117.00	\$1,056.58
Family	\$1,165.00	\$2,139.00	\$1,468.00	\$1,207.28
<b>18 Pay</b>				
	<b>TRS ActiveCare 1-HD</b>	<b>TRS ActiveCare 2</b>	<b>TRS ActiveCare Select</b>	<b>Scott &amp; White HMO</b>
Employee Only	\$85.33	\$401.33	\$204.00	\$205.69
Employee + Children	\$314.67	\$678.00	\$434.67	\$417.84
Employee + Spouse	\$544.00	\$1,180.00	\$744.67	\$704.39
Family	\$776.67	\$1,426.00	\$978.67	\$804.85
<b>26 Pay</b>				
	<b>TRS ActiveCare 1-HD</b>	<b>TRS ActiveCare 2</b>	<b>TRS ActiveCare Select</b>	<b>Scott &amp; White HMO</b>
Employee Only	\$59.08	\$277.85	\$141.23	\$142.40
Employee + Children	\$217.85	\$469.38	\$300.92	\$289.27
Employee + Spouse	\$376.62	\$816.92	\$515.54	\$487.65
Family	\$537.69	\$987.23	\$677.54	\$557.21