Canyon ISD Benefit Change Form

Employee Name: _____ Employee ID#: _____

Reason for Change: ☐ Marriage ☐ Divorce ☐ Employment Change ☐ Medicare/Medicaid
(Choose One)
☐ Birth/Adoption ☐ Death ☐ Loss of Coverage ☐ Dependent No Longer Eligible

Date of Change: _____ Documentation: (Choose One) ☐ Birth/Death Certificate
☐ Proof of Other Coverage ☐ Marriage License ☐ Divorce Decree ☐ Other

Effective Date: _____

(Effective date of change is the 1st of the month following the event date.)

Please complete the section below only for dependents you want to cover under any Benefit Plan							
Name (First, Middle Initial, Last)	Date of Birth (MM/DD/YY)	Medical	Dental	Vision	Dependent Life	Cancer	Gender
Spouse							M F
Dependent							M F
Dependent							M F
Dependent							M F
Dependent							M F
Dependent							M F
Dependent							M F
Please indicate if any of your dependents reside at an address other than your own. (Dependent's Name, Street, City, State, Zip)							

All Amounts Shown are Monthly Premiums
Clearly Indicate Your Selections

	ActiveCare HD	ActiveCare Primary	ActiveCare Primary+	West Texas Blue Essentials
Employee Only	$ 103.00	$ 111.00	$ 281.00	$ 285.50
Employee + Spouse	$ 791.00	$ 814.00	$ 1092.00	$ 1141.52
Employee + Child(ren)	$ 447.00	$ 420.00	$ 627.00	$ 617.16
Employee + Family	$ 1140.00	$ 1026.00	$ 1448.00	$ 1179.80

Waive Medical _____

Supplemental Life

Please see www.mybenefitshub.com for information about amounts and premiums.

Life Insurance Amount	Cost
$_____	$_____
Spouse Coverage Amount	
$_____	$_____

Waive Supplemental Life _____

Dependent Life

Yes No

$10,000 Coverage - $2.00 per month

$ 5,000 Coverage - $1.00 per month

Waive Dependent Life _____

Life Insurance Beneficiary Designation

I hereby request that any payment payable to a beneficiary(ies) after my death in accordance with the life insurance contract and/or the covered plan shall be paid to the beneficiary(ies) listed below. All previous beneficiary designations are cancelled. This designation includes, and is subject to, the Provisions set by the Life Insurance provider contracted with Canyon ISD. This beneficiary designation will be effective for any Canyon ISD provided or voluntary Life Insurance plan provided through Canyon ISD.

First Name	Last Name	Relationship	% to Pay	Primary or Contingent

Dental Coverage

Employee Only	**$ 38.84**
Employee + Spouse	**$ 74.42**
Employee + Child(ren)	**$ 88.43**
Employee + Family	**$123.99**

Waive Dental _____

Vision Coverage

	(VSP)
Employee Only	**$10.88**
Employee + 1 Dependent	**$20.46**
Employee + 2 or more Dependents	**$28.96**

Waive Vision _____

Salary Protection Coverage

***See www.mybenefitshub.com for information on Salary protection availability and premium cost**

Elimination Period	Monthly Benefit	Cost
_____Days	$_____	$_____

Waive Salary Protection _____

Cancer & Specified Diseases

***See www.mybenefitshub.com for information on availability and premiums.**

	Cancer only	Cancer + ICU
Employee Only		
Employee + Family		

Waive Cancer _____

Flexible Spending

Medical/Health Care	**$ _____ per paycheck**	**Annual Limits: Minimum $229.16 Maximum $2,750**
Dependent (Day) Care	**$ _____ per paycheck**	**Annual Limits: Minimum $300 Maximum $5,000**
HSA Account	**$ _____ per paycheck**	**Annual Limits: Maximum: Single - $3,550; Family $7,100**

I hereby authorize the above changes and amounts to be deducted from my pay.

Signature: _____ Date: _____

To be Completed by CISD Benefits:	Documentation Received: _____
	Entered into HUB: _____