Financial Benefit Services

BENEFIT ELECTION FORM

DISTRICT NAME _____

New Hire Enrollment ☐ **Termination** ☐ **Qualifying Event** ☐ **COBRA Election** ☐ **Information Update** ☐

1. Employee Information

Legal First Name _____ *(i.e. William)*

Legal Last Name _____ *(i.e. Smith)*

Social Security Number _____

Date of Birth _____ *(i.e. 01/01/1960)*

Gender _____

Home Address _____

City _____

State _____

Zip Code _____

Home Phone Number _____

Email Address _____

2. Payroll Information

Date of Hire _____ *(i.e. 09/15/2013)*

Annual Salary _____ *(i.e. $30,000)*

Pay Frequency _____ *(ie. Monthly, Semi-Monthly)*

Benefit Effective Date _____ *(i.e. 10/01/2013)*

#Hours Worked per Week _____ *(i.e. 20 hours/40 hours)*

3. Qualifying Event Change

Reason For Request _____

(i.e. marriage, divorce, death of spouse or dependent, birth of a child, job status change)

Effective Date of Change _____

4. Termination Request

Voluntary/Involuntary _____

Termination Date _____

Benefit Termination Date _____

5. I will participate in the Section 125 Cafeteria Plan (Pre-Tax Benefits)

Yes ☐

No ☐

6. Dependent Information

Spouse Name

Social Security Number _____

Date of Birth _____

Gender _____

Child Dependent Name

Social Security Number _____

Date of Birth _____

Gender _____

Child Dependent Name

Social Security Number _____

Date of Birth _____

Gender _____

Child Dependent Name

Social Security Number _____

Date of Birth _____

Gender _____

Child Dependent Name

Social Security Number _____

Date of Birth _____

Gender _____

Child Dependent Name

Social Security Number _____

Date of Birth _____

Gender _____

I understand and I have verifed the benefit selections I have made and authorize payroll deductions required for those selections. I also understand that any qualifying event change will not be made without proper documentation. If you need assitance, contact Financial Benefit Services at (800) 583-6908.

Employee Signature _____

Date Signed _____

Benefit Administrator Signature _____

Date Signed _____

BENEFIT ELECTIONS

FIRST NAME: **LAST NAME:**

BENEFIT NAME (i.e., dental, vision, disability, etc.)	PLAN NAME (i.e., PPO/DHMO/LOW/HIGH, etc.)	TIER LEVEL (Employee, Emp+Spouse, Emp+Children, Family)	BENEFIT AMOUNT (i.e., Elimination Periods/Benefit Amounts: 30/30 $1,000)	MONTHLY PREMIUM
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$

Primary Beneficiary	Contingent Beneficiary
Name(s)	Name(s)
Relationship	Relationship
Percentage(s):	Percentage(s):

Employee Signature _____ **Date Signed** _____

For Office Use Only

Benefit Administrator Signature _____ **Date Entered into TheBenefitsHUB** _____