Fort Worth INDEPENDENT SCHOOL DISTRICT

BENEFIT CHANGE FORM

Complete and return this form to the Benefits Dept. within 31 days of a status change.

Financial Benefit Services

Employee Information

Legal First Name _____ MI ____ (i.e. Elizabeth)

Legal Last Name _____ (i.e. Smith)

Social Security Number _____

Date of Birth _____ (i.e. 01/01/1970) M / F ____

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

For Employee Benefits Department Use Only

New Coverage Effective Date _____

Payroll Effective Date _____

Pay Frequency _____

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

Instructions: Place your initials in the box for the plan you wish to elect.

All Pre -Tax changes must correspond to a status change.

FIRST NAME: _____ **LAST NAME:** _____

TRS MEDICAL COVERAGE

Select Your Plan		Select Your Coverage Category	
ActiveCare HD	☐	Employee Only	☐
ActiveCare 2	☐	Employee + Spouse	☐
ActiveCare Primary (Requires PCP #*)	☐	Employee + Child(ren)	☐
ActiveCare Primary + (Requires PCP #*)	☐	Employee + Family	☐
Central & North Texas Baylor Scott & White HMO	☐		

Split Premium (Spouse with another TRS Health District) ☐

Pool Premium (FWISD Spouse) ☐

*PCP #: HO_____

Decline Medical ☐

UNITED CONCORDIA DENTAL

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

HUMANA ADVANTAGE PLUS DENTAL

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

HUMANA DHMO DENTAL

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Decline Dental ☐

HUMANA VISION COVERAGE

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Decline Vision ☐

THE HARTFORD DISABILITY PROTECTION

Elimination Period

- 14 Days ☐
- 30 Days ☐
- 45 Days ☐
- 90 Days ☐

Monthly Benefit Amount $_____

Benefit Duration

- 5 Years ☐
- SSNRA* ☐
- ***Cancel / Decline Disability*** ☐

Please Note: Cancelling Life or Disability coverage will make you and/or your Dependents subject to underwriting guide-lines and possible denial if you apply for coverage in FWISD in the future.

* SSNRA is the Social Security Normal Retirement Age

AMERICAN PUBLIC LIFE CANCER

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline Cancer ☐

FLEXIBLE SPENDING ACCOUNTS

	Annual Limit
Per Pay Day Medical Amount _____	$ 2,750
Per Pay Day Dependent Care Amount _____	$ 5,000

Decline Reimbursement Accounts ☐

HEALTH SAVINGS ACCOUNT

	Annual Limit
Per Pay Day Employee Amount _____	$ 3,600
Per Pay Day Family Amount _____	$ 7,200
Annual 55+ Catch-up Amount _____	

Cancel / Decline H.S.A ☐

* OPTIONAL LIFE AND AD&D

Employee Coverage Amount $_____

Cancel / Decline Employee Life ☐

* OPTIONAL DEPENDENT LIFE

Employee Coverage required to cover Dependents

Amount

- Optional Spouse Life $_____ ☐
- Optional Child Life $_____ ☐

Cancel / Decline Spouse Life ☐

Cancel / Decline Child Life ☐

CHUBB ACCIDENT GOLD PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline Accident ☐

CHUBB ACCIDENT DIAMOND PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline Accident ☐

MASA EMERGENT PLUS PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline MASA ☐

MASA PLATINUM PLAN

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Cancel / Decline MASA ☐