Arlington INDEPENDENT SCHOOL DISTRICT
More Than a Remarkable Education

Insurance Change Form

CHECKLIST FOR COMPLETING A QUALIFYIED 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.

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

EXAMPLES OF VALID SUPPORTING DOCUMENTATION

Life Event	Documentation Example
Marriage	Copy of Marriage Certificate
Divorce	Court Documents (must include Judge's 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.

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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)

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

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

MEDICAL

Plan: ☐ActiveCare Primary ☐ActiveCare HD ☐ActiveCare Primary+ ☐ ActiveCare 2 *(can only be elected if previously enrolled prior to 9/1/2020)* ☒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: ☐ Basic Vison ☐ Enhanced Vison

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 ☐ Platnium

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 $500,000)

GROUP LIFE - SPOUSE

Coverage Level: ☐ Waive _____ (Can elect up to 100% of employee amount in increments of $5,000 not to exceed $500,000)

GROUP LIFE – CHILD

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

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ACCIDENTAL DEALTH & 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)

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 hrbenefits@aisd.net or 682-867-4651 (fax)

TRS Medical Rates

2021-2022 TRS ActiveCare Health Insurance Premiums Without Wellness Program Incentive

	TRS ActiveCare Primary	TRS ActiveCare HD	TRS ActiveCare Primary+	TRS ActiveCare 2	Baylor Scott & White HMO
12 Pay – Administrators and Professionals					
Employee Only	$151.00	$163.00	$276.00	$747.00	$276.00
Employee + Spouse	$910.00	$943.00	$1,068.00	$2,136.00	$1,097.00
Employee + Children	$485.00	$506.00	$613.00	$1,241.00	$606.00
Family	$1,139.00	$1,179.00	$1,409.00	$2,575.00	$1,302.00
12 Pay – Para-Professionals					
Employee Only	$136.00	$148.00	$261.00	$732.00	$261.00
Employee + Spouse	$895.00	$928.00	$1,053.00	$2,121.00	$1,082.00
Employee + Children	$470.00	$491.00	$598.00	$1,226.00	$591.00
Family	$1,124.00	$1,164.00	$1,394.00	$2,560.00	$1,287.00
18 Pay					
Employee Only	$90.67	$98.67	$174.00	$488.00	$174.00
Employee + Spouse	$596.67	$618.67	$702.00	$1.414.00	$721.33
Employee + Children	$313.33	$327.33	$398.67	$817.33	$394.00
Family	$749.33	$776.00	$929.33	$1,706.67	$858.00
26 Pay					
Employee Only	$62.77	$68.31	$120.46	$337.85	$120.46
Employee + Spouse	$413.08	$428.31	$486.00	$978.92	$499.38
Employee + Children	$216.92	$226.62	$276.00	$565.85	$272.77
Family	$518.77	$537.23	$643.38	$1,181.54	$594.00

AISD contributes the following each month to employees participating in a medical plan:

- $266 per month for Professional employees
- $281 per month for all Para-Professional and Auxiliary employees
- The rates shown reflect the amount employees will pay if this district contribution amount is approved for the 2021-2022 plan year.

TRS Medical Rates

2021-2022 TRS ActiveCare Health Insurance Premiums With Wellness Program Incentive					
12 Pay – Administrators and Professionals					
	TRS ActiveCare Primary	**TRS ActiveCare HD**	**TRS ActiveCare Primary+**	**TRS ActiveCare 2**	**Baylor Scott & White HMO**
Employee Only	**$100.00**	**$112.00**	**$225.00**	**$696.00**	**$225.00**
Employee + Spouse	**$859.00**	**$892.00**	**$1,017.00**	**$2,085.00**	**$1,046.00**
Employee + Children	**$434.00**	**$455.00**	**$562.00**	**$1,190.00**	**$555.00**
Family	**$1,088.00**	**$1,128.00**	**$1,358.00**	**$2,524.00**	**$1,251.00**
12 Pay – Para-Professionals					
Employee Only	**$85.00**	**$97.00**	**$210.00**	**$681.00**	**$210.00**
Employee + Spouse	**$844.00**	**$877.00**	**$1,002.00**	**$2,070.00**	**$1,031.00**
Employee + Children	**$419.00**	**$440.00**	**$547.00**	**$1,175.00**	**$540.00**
Family	**$1,073.00**	**$1,113.00**	**$1,343.00**	**$2,509.00**	**$1,236.00**
18 Pay					
Employee Only	**$56.67**	**$64.67**	**$140.00**	**$454.00**	**$140.00**
Employee + Spouse	**$562.67**	**$584.67**	**$668.00**	**$1,380.00**	**$687.33**
Employee + Children	**$279.33**	**$293.33**	**$364.67**	**$783.33**	**$360.00**
Family	**$715.33**	**$742.00**	**$895.33**	**$1,672.67**	**$824.00**
26 Pay					
Employee Only	**$39.23**	**$44.77**	**$96.92**	**$314.31**	**$96.92**
Employee + Spouse	**$389.54**	**$404.77**	**$462.46**	**$955.38**	**$475.85**
Employee + Children	**$193.38**	**$203.08**	**$252.46**	**$542.31**	**$249.23**
Family	**$495.23**	**$513.69**	**$619.85**	**$1,158.00**	**$570.46**

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- **$266 per month for Professional employees**
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- **The rates shown reflect the amount employees will pay if this district contribution amount is approved for the 2021-2022 plan year.**