GRAPEVINE COLLEYVILLE INDEPENDENT SCHOOL DISTRICT

# BENEFIT CHANGE FORM

**You may add or cancel coverage during the Plan Year if you have a change in family status and notify GCISD ISD Benefits office within 30 days of change. Complete and return this form along with documentation of change.**

**www.gcisdbenefits.com**

FBS
A Higginbotham Partner

## 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

**Please check the box for the type of change and provide the date of 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 (If adding dependent, log into benefits portal and also add to your dependent page.

**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. I understand 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 Reviewed | Approved or Declined

# BENEFIT CHANGES

**Instructions: Place check boxes for only plans you wish to change.**

**First Name:** _____ **Last Name:** _____

## TRS-ActiveCare Medical Coverage

**Select Your Plan**

- UBC/CIGNA Basic ☐
- UBC/CIGNA Enhanced ☐
- ActiveCare HD ☐
- ActiveCare Primary (Requires PCP*) ☐
- ActiveCare Primary +(Requires PCP*) ☐
- ActiveCare 2 ☐
- Baylor Scott & White HMO ☐

**Select Your Coverage Category**

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

*PCP#: H0_____

*PCP#: H0_____

- Split Premium Primary** (Employee covers family, Spouse waives coverage at other TRS District) ☐
- Split Premium Secondary **(Employee waives coverage, covered by Spouse at other district.) ☐
- Pool Premium (GCISD Spouse) ☐
- ***Decline Medical*** ☐

** Splits not automatic, requires Admin Action and TRS Approval.

## The Hartford Hospital Indemnity

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

- ***Option 1/$500 HIP*** ☐
- ***Option 2/$1000 HIP*** ☐
- ***Option 3/$2000 HIP*** ☐
- ***Cancel / Decline HIP*** ☐

## Cigna Dental

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

- ***High Plan Dental*** ☐
- ***Low Plan Dental*** ☐
- ***Cancel / Decline Dental*** ☐

## QCD

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

- ***Cancel / Decline Discount Dental*** ☐

## Superior Vison

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

- ***Cancel / Decline Vision*** ☐

## The Hartford Disability Protection

Elimination Period

- 7 Days ☐
- 14 Days ☐
- 30 Days ☐
- 60 Days ☐
- 90 Days ☐
- 180 Days ☐

Note: Changes to Disability coverage will result in new pre-existing limitations.

Monthly Benefit Amount

_____

- ***Cancel / Decline Disability*** ☐

## APL Cancer

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

- ***High Plan Cancer*** ☐
- ***High Plan w/ICU Rider Cancer*** ☐
- ***Low Plan Cancer*** ☐
- ***Low Plan w/ICU Rider Cancer*** ☐
- ***Cancel / Decline Cancer*** ☐

## The Hartford Accident

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

- ***High Plan Accident*** ☐
- ***Low Plan Accident*** ☐
- ***Cancel / Decline Accident*** ☐

## Unum Voluntary Life

- Employee Coverage $_____
- Spouse Coverage $_____
- Child(ren) Coverage $_____

- ***Cancel / Decline Employee Life*** ☐
- ***Cancel / Decline Spouse Life*** ☐
- ***Cancel / Decline Child(ren) Life*** ☐

## UNUM AD&D Life

- Employee Coverage $_____
- Family Coverage $_____

- ***Cancel / Decline AD&D*** ☐

## Health Savings Account

| | Annual Limit |
|---|---|
| Monthly Employee Amount _____ | $ 3,600 |
| Monthly Family Amount _____ | $ 7,200 |
| Monthly 55+ Catchup _____ | |

- ***Cancel / Decline HSA*** ☐

## Flexible Spending Accounts

| | Annual Limit |
|---|---|
| FSA Monthly Deduction: _____ | $ 2,750 |
| Dependent Care Monthly _____ | $ 5,000 |

- ***Cancel / Decline Reimbursement*** ☐

NOTE: Employee Life required for Spouse/Child. Evidence of insurability maybe required to change life election's or to reinstate if cancelled. Be sure to log in and designate beneficiary.

Amount