



BENEFIT CHANGE FORM 2022-23

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

www.gcisdbenefits.com



A Higginbotham Partner

Employee Information

Legal First Name _____	MI _____	Legal Last Name _____	Last 4 of Social Security _____	M / F _____
(i.e. Elizabeth)		(i.e. Smith)		
Home Address _____	City _____	State _____	Zip Code _____	Home / Cell Preferred Phone Number () _____
Work Phone Number () _____	Ext. _____	Primary 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.)

<u>Dependent Name</u> _____	<u>Dependent Name</u> _____
Social Security Number _____	Social Security Number _____
Date of Birth _____ M / F _____	Date of Birth _____ M / F _____
Relationship _____	Relationship _____
<u>Dependent Name</u> _____	<u>Dependent Name</u> _____
Social Security Number _____	Social Security Number _____
Date of Birth _____ M / F _____	Date of Birth _____ M / F _____
Relationship _____	Relationship _____

Payroll Information

<u>For Employee Benefits Department Use Only</u>	New Coverage Effective Date _____	Payroll Effective Date _____	Pay Frequency _____
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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 _____

2022-23 PlanYear Benefit Changes

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

FIRST NAME:

LAST NAME:

UBC- ALLIANCE

Select Your Plan

Value HD
 Basic HD (HSA compatible)
 Standard
 Enhanced

Select Your Coverage Category

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

Pooled Premium (GCISD Spouse)

Decline Medical

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 DISCOUNT DENTAL

Employee Only
 Employee + Spouse
 Employee + Child(ren)
 Employee + Family
 Cancel / Decline Discount Dental

SUPERIOR VISION

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

Monthly Employee Amount Annual Limit \$ 3,650
 Monthly Family Amount \$ 7,300
 Monthly 55+ Catchup
 Cancel / Decline HSA

FLEXIBLE SPENDING ACCOUNTS

FSA Monthly Deduction: Annual Limit \$ 2,850
 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.