BENEFIT ELECTION/CHANGE FORM

☐ New Hire Enrollment ☐ Qualifying Event ☐ Termination

Section 1 - Life Event Change **(Only complete if qualifying event)**

You may make elections changes during the Section 125 Plan Year if you have a qualifying event and you notify the Benefits Department within 31 days of the event. **Please complete all information.**

Reason for request: ☐ Marriage / Divorce ☐ Death of a Spouse or Dependent ☐ Birth or Adoption of a Child ☐ Loss of Coverage ☐ Job Status Change for Employee or Spouse ☐ Termination/Commencement of Spouse's Employment

☐ Other (Please Explain): Effective Date of Change: / /

Section 2 – Employee Information (*Please Print*)

Employee Name:			Social Security Number	Date of Birth:
Gender:	Marital Status:	Phone Number:	Email address:	
Mailing Address:				
Physical Address *(required if mailing address is PO Box)* :				

For the Benefits Department use only:			
Annual Salary: $	Hire Date:	Occupation:	Location:
Hours worked:	Pay Frequency: __12 ___20 ___26	Effective Date:	Termination Date:

Section 3 – Family Information (*Please Print*)

Dependent Name	SSN	DOB	M/F	Add or Drop
Spouse				
Child				
Child				
Child				
Child				

Section 4 – Benefit Selection (*Please indicate election by using an "X"*)

TRS Medical ☐ Decline

Effective: ☐ Actively at Work Date ☐ First day of month following

☐ Activecare 1-HD ☐ Activecare Select ☐ Activecare 2

☐ First Care ☐ Scott & White

☐ Employee Only ☐ Employee & Child(ren)

☐ Employee & Spouse ☐ Employee & Family

☐ Split Premium (Spouse works at other district–additional form is required)

☐ Pooled Premium (Spouse is also employed by CISD)

Flexible Spending Accounts ☐ Decline

☐ Medical Reimbursement (*Maximum Annual Amount - $2,550)*
$_____ Annual Contribution

☐ Dependent Care Reimbursement (*Maximum Annual Amount - $5,000)*
$_____ Annual Contribution

Ameritas Dental ☐ Decline

☐ Employee Only ($29.96)
☐ Employee Spouse ($63.88)
☐ Employee Children ($70.12)
☐ Employee & Family ($103.96)

Superior Vision ☐ Decline

☐ Employee Only ($7.14)
☐ Employee Spouse ($12.16)
☐ Employee Children ($12.84)
☐ Employee & Family ($19.30)

AFA Disability ☐ Decline

Elimination Period:

☐ 14 Day ☐ 30 Day ☐ 60 Day
☐ 90 Day ☐ 150 Day

Monthly Benefit Amount: $

Monthly Premium: $_____

AFA Accident ☐ Decline

Choose one: Basic Plan Or Enhanced

☐ Employee Only
☐ Employee/Children
☐ Employee/Spouse
☐ Employee & Family Premium: $_____

Assurant GAP ☐ Decline

Choose one: High Plan Or Low Plan

☐ Employee Only
☐ Employee/Spouse
☐ Employee/Children
☐ Employee & Family Premium: $_____

Texas Life ☐ Decline

☐ Employee $_____
☐ Spouse $_____
☐ Child(ren) $25,000 or $50,000

Allstate Critical ☐ Decline

☐ Employee $_____
☐ Spouse $_____
☐ Child(ren) $_____

Assurant Group Life ☐ Decline

☐ Employee Coverage $_____
Premium $_____

☐ Spouse Coverage $_____
Premium $_____

☐ Child(ren) $10,000

Legal Shield ☐ Decline

☐ ID Theft Only
☐ Legal Shield Only
☐ Both

Allstate Cancer ☐ Decline

☐ Employee $_____
☐ Spouse $_____
☐ Child(ren) $_____

Section 5 – Beneficiary Designation (*Please Print)*

Primary Beneficiary:

Name_____

Date of Birth_____

Relationship_____

Percentage_____

Contingent Beneficiary:

Name_____

Date of Birth_____

Relationship_____

Percentage_____

Section 6 - Signatures

This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status. I understand that I have verified the benefits elected above and authorize any payroll deductions required for those elections.

Employee Signature: x_____ Date: _____/_____/_____

Benefits Administrator Signature: x_____ Date: _____/_____/_____