# IRVING ISD 2017-2018 BENEFITS CHANGE FORM

**EFFECTIVE DATE OF CHANGE:** _____

| **Employee Name (Last, First, Middle)** | **Title/Position** | **Social Security Number** | **Employee ID#** |
|---|---|---|---|
| **Home Address (Street, Apt.#)** | **City State Zip Home Phone Number** ( ) | **Date of Birth** | **Pay Period** ☐ **Monthly** ☐ **Biweekly** |

## REASON FOR REQUEST

You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Human Resources-Compensation Benefits Office within 31 days of the change. Proof of change is required. Your request will be denied if you fail to notify the Human Resources-Compensation Benefits Office within 31 days. Complete "Covered Family Members" section with the names of family members to be added or canceled.

## CHECK REASON FOR CHANGE

☐ Marriage ☐ Divorce ☐ Birth/Adoption of a child/Gains legal guardianship ☐ Death of spouse or dependent ☐ Dependent becomes eligible ☐ Dependent becomes ineligible ☐Loses Coverage

☐ Loss of other qualified group coverage ☐ Spouse changes employment - Gains Coverage ☐ Spouse changes employment - Loses Coverage ☐ Other - Explain_____

**(COMPLETE CHART WITH CHANGES RELATIVE TO THE QUALIFIED EVENT INFORMATION EMPLOYEE IS PROVIDING)**

| COVERAGE | ☐ Add ☐ Remove ☐ Change | Plan Level or Amount |
|---|---|---|
| **Medical** | ☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family** | ☐ **Plan 1 HD** ☐ **Select** ☐ **Plan 2** ☐ **S&W HMO** |
| **HSA** | ☐ **Employee** ☐ **Family** | **Amount Per Pay Period $** **Annual Max: Ind. $3,400 Fam. $6,750** |
| **Medical Reimbursement (Flexible Spending)** | ☐ **Employee** | **Amount Per Pay Period $** **Annual Max :$2,550** |
| **Medlink Medical Gap Plan** | ☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family** | ☐ **Option 1 - $1500** ☐ **Option 2 - $2500** |
| **Dental** | ☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family** | ☐ **DMO Facility #_____** ☐ **High PPO** ☐ **Low PPO** |
| **Vision** | ☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family** | |
| **Cancer** | ☐ **Employee** ☐ **Employee + Child(ren)** ☐ **Employee + Family** | ☐ **High Option Basic Plan** ☐ **Basic + ICU Rider** ☐ **Low Option Basic Plan** ☐ **Basic + ICU Rider** |
| **Disablity** | ☐ **Employee** | **Waiting Period** **Coverage $** |
| **Group Life** | ☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** | **Policy** **EE $** **K SP $** **_K CH $** **_K** |
| **Dependent Care Reimbursement** | ☐ **Employee** | **Amount Per Pay Period $** **Annual Max $5,000** |
| | ☐ | |

## COVERED FAMILY MEMBERS INFORMATION

If adding a qualified family member, you must complete all family member information requested. If changing coverage, only list the member(s) with the qualified change.

**SPOUSE** _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

**CHILD** _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

**CHILD** _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

**CHILD** _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

**For Office Use:**

[ ] Accepted [ ] Denied

Date Received:_____

Received by :_____

**Important:** I understand and have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand that the above selections may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I also understand that changes resulting in the addition of coverage will be effective the 1st day of the month following the qualifying event. I will be responsible for paying back any missed premiums. If dropping coverage, the effective date will be the 1st of the month following the signature date.

Signature _____ Date _____

**Please fax completed form and supporting documentation to the Benefits Office at 972.215.5239**

## TRS MEDICAL INSURANCE

12 Pay Rates

| Tier | ActiveCare 1-HD | ActiveCare Select | ActiveCare 2 | Scott & White HMO |
|---|---|---|---|---|
| Employee Only | $0 | $163 | $363 | $210.04 |
| Employee + Spouse | $640 | $913 | $1343 | $912.08 |
| Employee + Children | $320 | $483 | $711 | $537.42 |
| Employee + Family | $965 | $1238 | $1653 | $1049.98 |

## SUPERIOR VISION

$125 frame allowance and $130 contact lens allowance.
Exam/Lenses/Contacts: 12 months and Frames 12 months.

| | |
|---|---|
| Employee Only | $7.98 |
| Employee + Spouse | $15.76 |
| Employee + Children | $15.44 |
| Employee + Family | $23.50 |

## CIGNA DENTAL

**High PPO**
Calendar year maximum of: $1,500 per insured person.

| Tier | 12 Pay Rates |
|---|---|
| Emp Only | $31.88 |
| Emp + Spouse | $54.58 |
| Emp + Children | $75.96 |
| Emp + Family | $106.90 |

**Low MAC Plan**
Calendar year maximum of: $750 per insured person.

| Tier | 12 Pay Rates |
|---|---|
| Emp Only | $22.34 |
| Emp + Spouse | $38.30 |
| Emp + Children | $53.30 |
| Emp + Family | $74.98 |

**DHMO**
Participant must choose an in-network primary care dentist.

| Tier | 12 Pay Rates |
|---|---|
| Emp Only | $14.62 |
| Emp + Spouse | $29.24 |
| Emp + Children | $37.42 |
| Emp + Family | $41.08 |