

BIRDVILLE ISD BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE: _____

Employee Name (First, Middle, Last)			Title/Position	Employee ID#
Campus ID#	Work Phone Number	Contact Phone Number	Date of Birth	Pay Period
				12 checks 26

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
- ☐ 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

COVERAGE	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Plan Level or Amount
Medical	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Plan 1 HD <input type="checkbox"/> Plan 2 <input type="checkbox"/> Select Plan <input type="checkbox"/> HMO
Medlink Medical Gap Plan	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	
Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> DMO <input type="checkbox"/> High PPO <input type="checkbox"/> Low PPO
Vision	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	
Cancer	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> High Option Basic Plan <input type="checkbox"/> Basic + ICU Rider <input type="checkbox"/> Low Option Basic Plan <input type="checkbox"/> Basic + ICU Rider
Disability	<input type="checkbox"/> Employee	Waiting Period Monthly Coverage \$
Voluntary Group Term Life	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	EE \$ SP \$ CH \$10,000
Medical Reimbursement (circle one) FSA or HSA	<input type="checkbox"/> Employee	Amount Per Pay Period \$
Dependent Care Reimbursement	<input type="checkbox"/> Employee	Amount Per Pay Period \$ Annual Max \$5,000
Identity Theft Protection	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family	
Accidental Death & Dismemberment	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family	
MetLaw (legalservices)	<input type="checkbox"/> Employee	
5Star (individual) Life	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse	EE Amount \$ Spouse Amount \$
MASA (emergency transport)	<input type="checkbox"/> Employee + Family	

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: _____

Fax to Benefits Office @ 817-547-5580