BIRDVILLE ISD 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** ☐ **12 Pay** ☐ **26 Pay**

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 Benefits Department within 31 days of the change. Proof of change is required. Your request will be denied if you fail to notify the 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

☐ 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**	**Plan Level or Amount**
Medical	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	☐ **Plan 1 HD** ☐ **Plan 2**
Medlink Medical Gap Plan	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	
Dental	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	☐ **DMO** ☐ **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**
Disability	☐ **Employee**	**Waiting Period** **Coverage $**
Group Life	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)**	**Policy** **EE $** **K** **SP $** **_K CH $** **K**
Medical Reimbursement FSA or HSA	☐ **Employee**	**Amount Per Pay Period $** **Annual Max $2,500**
Dependent Care Reimbursement	☐ **Employee**	**Amount Per Pay Period $** **Annual Max $5,000**
Identity Theft Protection	☐ **Employee** ☐ **Employee + Family**	

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 Benefits Department Use:

☐ Accepted ☐ Denied

Date Received _____

Entered in Benefits Hub: _____

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 817-831-5721