BIRDVILLE ISD BENEFITS CHANGE FORM

Employee Name (First, Middle, Last)	Employee ID#	Date of Birth	Contact Phone Number

➢ **CHECK REASON FOR CHANGE (QUALIFYING EVENT):**

☐ Marriage/Divorce ☐ Birth/Adoption/Legal Guardianship change of a child ☐ Death of a dependent

☐ Change in dependent eligibility ☐ Gain/loss of other coverage ☐ Other _____

Date of Qualifying Event (if applicable) _____ (required support documentation is listed on page 2)

➢ **PLEASE SELECT BELOW YOUR *NEW* ENROLLMENT ELECTION**

COVERAGE	CANCEL	ENROLL/CHANGE COVERAGE TIER TO	ENROLL/CHANGE PLAN LEVEL OR AMOUNT TO
Medical (TRS)	☐	☐ EE ☐ EE and SP ☐ EE and CH ☐ Family	☐ AC HD ☐ AC Primary* ☐ AC Primary+ * ☐ Scott & White * Requires selecting an in-network provider below
Hospital Indemnity Plan (The Hartford)	☐	☐ EE ☐ EE and SP ☐ EE and CH ☐ Family	☐ Plan 1 ($1,500) ☐ Plan 2 ($2,500)
Cancer (American Public Life)	☐	☐ EE ☐ EE and CH ☐ EE, SP and/or CH	☐ Level 1 ☐ Level 1 + ICU ☐ Level 2 ☐ Level 2 + ICU
Disability (Cigna)	☐	☐ Premium Plan ☐ Select Plan	Waiting Period (days) ☐ 7 ☐ 14 ☐ 30 ☐ 60 ☐ 90 ☐ 180 Monthly Coverage Amount $
Group Term Life (One America)	☐	☐ EE ☐ Spouse ☐ Child(ren)	EE $ SP $ CH $10,000
AD&D (One America)	☐	☐ EE ☐ Family	Amount $
Dental (Delta)	☐	☐ EE ☐ EE and SP ☐ EE and CH ☐ Family	☐ DHMO* ☐ PPO Low ☐ PPO High * Requires selecting an in-network provider below
Vision (Superior)	☐	☐ EE ☐ EE and SP ☐ EE and CH ☐ Family	
ID Theft Protection (IDGuard)	☐	☐ Employee ☐ Family	☐ Total (1 bureau) ☐ Premier (3 bureau)
Legal Services (MetLaw)	☐	☐ Family	
Health Reimbursement Plans (EECU/NBS)	☐	☐ HSA ☐ FSA **(Check only one)**	Amount Per Pay Period $
Dependent Care Reimbursement (NBS)	☐		Amount Per Pay Period $
Emergency Transport (MASA)	☐	☐ Family	

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PLEASE ENTER A (ADD) OR D (DELETE) OR LEAVE BLANK THE BOXES BELOW FOR EACH BENEFIT												
EMPLOYEE/DEPENDENT NAME	**Date of Birth**	**Medical**	**HIP**	**Cancer**	**Grp Term Life**	**AD&D**	**Individual Life**	**Dental**	**Vision**	**ID Theft**	**Legal**	**Emergency Transport**
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Enter provider name and city or provider number here	**MEDICAL (AC Primary and AC Primary+ Only):**						**DENTAL (Dental HMO Only):**					
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Enter provider name and city or provider number here	**MEDICAL (AC Primary and AC Primary+ Only):**						**DENTAL (Dental HMO Only):** -					
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Enter provider name and city or provider number here	**MEDICAL (AC Primary and AC Primary+ Only):**						**DENTAL (Dental HMO Only):**					
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Enter provider name and city or provider number here	**MEDICAL (AC Primary and AC Primary+ Only):**						**DENTAL (Dental HMO Only):**					

Important: I understand and have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand 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. Any addition of coverage will be effective the first day of the month following the qualifying event. I will be responsible for paying back any missed premiums. Any deletion of coverage will be effective the 1st of the month following the later of the qualifying event or document submission date.

Signature: _____ Date: _____

Fax to the Benefits Office @ 817-547-5580 or email to susan.dippolito@birdvilleschools.net. If you are adding a dependent, please log into THE*benefits*HUB and add the dependent's demographic information. A social security number is required unless the dependent is a new born.

- **QUALIFYING EVENT SUPPORT DOCUMENTATION REQUIREMENTS:**
  - Marriage – submit a copy of the marriage certificate.
  - Divorce – submit a copy of the Dissolution of Marriage.
  - Birth of Child – submit documentation of birth from the hospital, such as a Proof of Vital Facts. When received, please enter the dependent's social security number via THE*benefits*HUB.
  - Adoption/Legal Guardianship – submit certified court paperwork.
  - Loss of other coverage or change – provide proof of loss of coverage such as a COBRA letter or notice from the employer.
  - Gain other coverage (other group coverage or Marketplace coverage) – provide proof of other coverage such as a copy of the new card or enrollment confirmation.