MESQUITE ISD
BENEFIT ELECTION FORM

EMPLOYER: Mesquite Independent School District, 3819 Towne Crossing Blvd., Mesquite, TX 75150 | EMPLOYEE ID #:

EMPLOYEE (Full legal name):

SOCIAL SECURITY #:

ADDRESS:

CITY, ST, ZIP:

DOB:

CAMPUS:

POSITION:

+ If Status Change, check one of the following Section 125 qualifying events that you have experienced within **31 days** (Change of election(s) must be relevant to the circumstance causing the change.):

ADDING COVERAGE DUE TO:

- ___ Marriage (___copy of license)
- ___ Divorce* (___final decree)
- ___ Death of Spouse* (___LOE needed)
- ___ Death of Dependent* (___LOE needed)
- ___ Child Birth (___VBF needed)
- ___ Adoption (___legal paperwork needed)
- ___ Court Appointed Dependent-Medical Support Order
- ___ Job Status Change*
- ___ Involuntary Loss of Prior Coverage* (___LOE needed)

*To add health insurance, the Qualifying Event must result in loss of coverage.

DROPPING COVERAGE DUE TO:

- ___ Obtained New Coverage w/spouse's employer, Marketplace, Medicare or Medicaid (Proof needed)
- ___ Covered Dependent Ceases to Satisfy Eligibility Requirements (LOE needed)

SELECT ONE OF THE FOLLOWING:

- ☐ **New Employee**
  Hire date: _____
- ☐ **Status Change+**

Effective Date - Health Ins.: _____

Effective Date – Other Ins.: _____

Date of Qualifying Event: _____

IS YOUR SPOUSE A MISD EMPLOYEE?

- ☐ Yes
- ☐ No

If Yes, list name: _____

PAY TYPE:

- ☐ Monthly
- ☐ Semi-Monthly

DECLINATION ON FILE?

- ☐ Yes
- ☐ No
- ☐ N/A

I have elected/declined participation in the following benefits:			PRIOR COVERAGE	SECTION 125	NON-SECTION 125
BENEFIT ELECTION	ENROLL	DECLINE or CANCEL	List prior deduction for status change:	Before-tax salary deduction: (Per Pay Amt)	After-tax salary deduction: (Per Pay Amt)
Medical Insurance	☐	☐			
Dental Insurance	☐	☐			
Vision Insurance	☐	☐			
Cancer Insurance – Loyal American		☐			
Benefits Enhancer Bundle - Accident/Critical Illness	☐	☐			
Disability Insurance	☐	☐			
GAP Insurance – Colonial Life		☐			
Hospital Indemnity – MetLife	☐	☐			
Unreimb. Med. Expense (must elect yearly)	☐	☐			
Child/Dependent Care (must elect yearly)	☐	☐			
Flex Spending Card	☐	☐			
H.S.A. – Health Savings Account	☐	☐			
Legal Insurance	☐	☐			
I.D. Shield	☐	☐			
Accidental Death & Dismemberment	☐	☐			
Supplemental Life – Employee	☐	☐			
Supplemental Life – Spouse	☐	☐			
Supplemental Life – Dependent	☐	☐			
CHUBB – Lifetime Benefit Term	☐	☐			

Note: I understand that by voluntarily canceling medical, dental, or vision coverage at any time, I am forfeiting my rights [and covered dependent(s) rights] to continuation of that benefit coverage (COBRA).

➢ **EMPLOYEE MUST INITIAL UPON CANCELATION OF COVERAGE** _____

BY SIGNING THIS FORM:

☐ If enrolling - I understand that (1) My Social Security benefits may be slightly reduced as a result of this election. (2) My annual withholding (W-2) form will reflect my reduced taxable income. (3) I cannot change or revoke this election during the Plan Year unless an exception applies. (4) My employer may cancel this election, if necessary, to comply with the provisions of the Internal Revenue Code. (5) My portion of the cost of the Benefit Plan paid with before-tax dollars will automatically increase or decrease, as the case may be, to reflect the change in the cost of benefits.

☐ If declining - I acknowledge that I have been given the opportunity to participate in the Benefits offered by my employer under the Flexible Benefit Plan and decided not to enroll in any benefits offered under the Flexible Benefits Plan. I understand that I will not be able to participate in the Flexible Benefit Plan until the enrollment period for the next plan year unless I have a qualifying circumstance in accordance with Internal Revenue Code Section 125.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

(Form Modified 2/12/2019)