Spring Branch Independent School District

Benefits 2020-2021
Substitute Benefits Declaration Form

Spring Branch ISD Benefits Department
713-464-1511

SUBSTITUTE INFORMATION

Last Name:_____ First Name: _____ MI: _____

Address: _____
Street City State Zip Code

Employee ID#: _____ Date of Birth: _____

BENEFIT ELECTIONS

Spring Branch ISD reasonably expects substitutes to work at least 10 hours each week; however, the district does not guarantee that you will receive 10 hours every week. Since you are expected to work at least 10 hours each week, you are eligible to enroll in TRS ActiveCare health insurance; however, you will not receive the District's contribution to your health insurance premiums. As a substitute, you are not eligible for any other supplemental benefits. Please see the next page for the health insurance premium rates.

This is to certify that I have been given the opportunity to apply for the TRS ActiveCare benefits offered to me and my eligible dependents and have made the below decision regarding all insurance coverage available to me.

☐ I do not plan to work 10 or more hours per week; therefore, choosing to decline all TRS ActiveCare benefits for the 2020-2021 plan year. I understand that I am not eligible for benefits based on my number of work hours and SBISD will limit my work hours to less than 10 hours per week based on my decision. I understand that in making this choice I cannot enroll in benefits until the next annual open enrollment period unless I have a qualifying event as defined by federal law.

☐ I am choosing to decline all TRS ActiveCare benefits for the 2020-2021 plan year. I understand that in making this choice I cannot enroll in benefits until the next annual open enrollment period unless I have a qualifying event as defined by federal law.

☐ I am choosing to make TRS ActiveCare benefit elections for coverage for the 2020-2021 plan year. I understand that I will need to enroll for benefits by completing the required health insurance benefits forms within 31 days of my approval as a district substitute for any coverage to be effective.

This completed form must be received by the SBISD Benefits Department no later than 31 days from your acceptance as a district substitute.

_____ _____
Signature Date

Please sign and return this form within 31 days of your approval as a district substitute to the following address:

SBISD Benefits Department

955 Campbell Road

Houston, TX 77024