Kyrene Employee Benefit Trust – KEBT

Employee Benefits Life Event Form

Policy #210475

Welcome to KEBT! As a Kyrene School District employee who works 30 hours or more per week, you have a number of employee benefit options. Kyrene is pleased to be able to offer employees up to a $6,480 annual medical plan allowance; as part of your total compensation. The allowance covers the cost of employee only coverage on the HDHP Health Savings Account medical plan and includes a $600 HSA deposit for employees who choose the plan. The allowance applied for the Choice EPO medical plan is $5,352.

A $50,000 basic life insurance is provided to you at no charge. Benefits such as medical, dental, vision, short-term disability, critical illness/accidental injury, voluntary life, and the flexible spending accounts, give you the opportunity to enroll and pay by convenient payroll deductions, or waive coverage for those benefits you choose not to elect. Most benefits become effective on the first day of the month following 60 days of employment with the Kyrene School District. Certain benefits require additional forms to be completed. Please be certain to return all necessary forms. If a benefit requires underwriting by the carrier, the effective date will be the date of the approval.

You must complete all of your enrollment forms and provide the necessary proof of dependent status, as requested, within 31 days of most life events.

If you have any questions regarding the completion of this form, please contact the Benefits Department in Human Resources Services.

KEBT Life Event Form – Instructions

Plan informational materials are posted on the Kyrene website under Human Resource Services, Benefits.

⇒ **If making changes to coverage:** Fill out all sections of this form. If there is not a change in a particular section, please enter current information, or write “no changes” in that section. Be sure to sign and date this form and make a copy for your records.

⇒ A verification of previous coverage may be required from your previous employer or previous insurance carrier. The verification needs to show dates of coverage on your current or prior insurance plan for all covered individuals in your family and must be approved by Kyrene benefits staff prior to obtaining KEBT insurance. Please submit the verification of previous coverage with this enrollment form.

Revised 03/29/2024

REFERS TO Medical Insurance

I understand that:

- ⇒ **If I qualify for a special enrollment or life event, as defined in the Summary Plan Description that was given to me, I am responsible to inform the Benefits office of a change in my status, within 31 days of the event.**
- ⇒ If I decline coverage during this special enrollment opportunity, coverage will not be available to me.
- ⇒ If I do not qualify for or elect special enrollment, as more fully explained in the Summary Plan Description that is posted online, I will not be able to enroll in the Plan until next enrollment period.

I acknowledge that I completed this form and that I am advised to make a copy so that I will understand my rights to special enrollment in the event the coverage described above is ended for reasons beyond my control.

IRS Guidelines for Health Savings Account (HSA)

Health Savings Account Notices

- It is the responsibility of the employee to ensure that deposits into the HSA bank account do not exceed the IRS calendar year maximum deposit. The employer deposit into an employee's HSA counts toward the calendar year maximum. For more information visit www.irs.gov
- HSA bank accounts must maintain at least a $1.00 balance each month to avoid account closure. Accounts that are closed due to a zero balance must be re-opened by the employee. A new account number and HSA debit card will be issued.
- HSA bank accounts with less than $500 balances are charged a $1.00 per month bank fee.

Kyrene School **District**

2024/2025 Benefit Enrollment Life Event Form

Hire Date:_____Effective Date: _____

☐ Life Event Reason_____

☐ Adding/Deleting Dependents_____

1. EMPLOYEE INFORMATION (Please print allinformation)

Name:		SSN:
Address:		Phone#
Birthdate:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single
School or Department:	Occupation:	

2. MEDICAL COVERAGE (Pre-Tax) -**Annual/Monthly Rates**

Please choose ONE of the following Medical Plans and Coverage Level:

Medical Plan #1: AmeriBen/BCBS Statewide - HDHP Health Savings Account (H.S.A)

	Annual Cost	District Paid Allowance	*District HSA Deposit	Employee Annual Cost	Employee Monthly Cost
☐ Employee Only	$6,480.00	$6,480.00	*$600.00*	$0	**$0**
☐ Employee + Spouse	$13,104.00	$6,480.00	*$600.00*	$6,624.00	**$552.00**
☐ Employee + Child(ren)	$10,464.00	$6,480.00	*$600.00*	$3,984.00	**$332.00**
☐ Employee + Family	$15,492.00	$6,480.00	*$600.00*	$9,012.00	**$751.00**

Additional HSA contribution **$_____(Annually) *** The District paid $600 HSA deposit is pro-rated for actual months of coverage.

Medical Plan #2: AmeriBen/BCBS Statewide - PPO

	Annual Cost	District Paid Allowance	Employee Annual Cost	Employee Monthly Cost
☐ Employee Only	$7,164.00	$5,352.00	$1,812.00	**$151.00**
☐ Employee + Spouse	$15,108.00	$5,352.00	$9,756.00	**$813.00**
☐ Employee + Child(ren)	$11,976.00	$5,352.00	$6,624.00	**$552.00**
☐ Employee + Family	$17,952.00	$5,352.00	$12,600.00	**$1,050.00**

☐ **Waive Medical Plan**

3. DENTAL/VISION PLANS (Pre-Tax PayrollDeductions) –Annual Rates

P**lease check the level of coverage:**

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	
Avesis-VISION	☐ $108.00	☐ $228.00	☐ $168.00	☐ $276.00	☐ Waive
Cigna Dental- PPO	☐ $612.00	☐ $1,284.00	☐ $1,008.00	☐ $1,536.00	☐ Waive
Cigna Dental -DHMO	☐ $119.76	☐ $233.52	☐ $251.40	☐ $335.40	☐ Waive

Office Use Only:

Prior Coverage/ Dates: **New Coverage/Dates:**

4. DEPENDENT INFORMATION (Please print the requested information about each dependent and mark the applicable coverage).

Name (Last, First, MI)	Sex	Relationship	SS #	Birth Date	Med	Dental	Vision	Life

*Employees enrolling a domestic partner must attach a completed Domestic Partner Affidavit

5. BENEFICIARY DESIGNATION

Beneficiaries	Name	Relationship	Birth Date	SS #	% of Share
Primary					
Contingent					

6. Signature

I have read the information on this form and I understand the benefit choices I have made. I authorize Kyrene School District to take payroll deductions for all benefits selected. I understand that if this form is being used for new hire enrollment and I waive the opportunity to complete this enrollment, I will have to wait until next year's open enrollment to make elections, unless I meet the exceptions for special enrollment or life event as defined in the KEBT Summary Plan Description. If requesting dependent coverage, I understand that I must provide acceptable evidence of relationship for all dependents within 31 days of eligibility, as may be required. My signature below indicates my desire to implement the benefit elections listed on this form, my agreement with all noted certifications and that I have received or have access to the plan documents for the coverages that I have elected online at www.kyrene.org/ Departments/Human Resource Services/Employee Benefit Information. I also understand that if I did not mark an election, a waiver of that benefit is implied.

Employee Signature:_____ **Date:** _____

SOCIAL SECURITY DISCLOSURE: Disclosure of your Social Security number is permitted under Section 7 of the Federal Privacy Act of 1974. For health insurance and other employee benefit plans: vendors may indicate that SSN's are mandatory to identify individuals enrolling for coverage. Further, a new Mandatory Insurer Reporting law, Section 111 of Public Law 110-173, requires group health plan insurers to report SSN's in order for Medicare to coordinate payments with other insurance benefits. The SSN's for you and those of your family may be requested for these purposes. If you have questions about when or why a particular plan requires your social security number please contact the vendor directly.