MESQUITE INDEPENDENT SCHOOL DISTRICT

Benefit Change Form

Complete and return this form to the Benefits Dept. within 31 days of a status change.

First Financial Administrators, Inc.

Employee Information

Legal First Name _____ MI _____ Legal Last Name _____ Social Security Number _____ Employee ID Number _____

Home Address _____ City _____ State _____ Zip Code _____ Date of Birth _____

Phone Number _____ Work Email Address _____ **Qualifying Life Event Date** _____

Dependent To Add ☐ or Drop ☐

Dependent Name _____

Social Security Number _____ Date of Birth _____

Relationship _____ M / F _____

Dependent To Add ☐ or Drop ☐

Dependent Name _____

Social Security Number _____ Date of Birth _____

Relationship _____ M / F _____

Dependent To Add ☐ or Drop ☐

Dependent Name _____

Social Security Number _____ Date of Birth _____

Relationship _____ M / F _____

Dependent To Add ☐ or Drop ☐

Dependent Name _____

Social Security Number _____ Date of Birth _____

Relationship _____ M / F _____

Reason	Add	Drop
Marriage or Divorce	☐	☐
Birth or Adoption	☐	☐
Death of Dependent	☐	☐
National Medical Support Notice/ Court Order	☐	☐
Involuntary Loss Of Coverage	☐	☐
Obtained New Coverage	☐	☐
Obtained Medicare	☐	☐
Dependent Ceases Eligibility	☐	☐

I hearby certify that the above information is true and correct to the best of my knowledge and that evidence of the above events must be submitted to the Plan Administrator. I understand that Change in Family Status is subject to validation and approval of Administrator. Signature _____ Date_____

BENEFIT CHANGES FORM

MESQUITE INDEPENDENT SCHOOL DISTRICT

ONLY SELECT THOSE BENEFITS FOR WHICH YOU ARE COMPLETING A CHANGE FOR DURING THIS LIFE EVENT.

Health - BlueCross BlueShield

		Select Your Coverage	
PPO HIGH DEDUCTIBLE PLAN	☐	Employee Only	☐
EPO LOW PLAN	☐	Employee + Spouse	☐
EPO HIGH PLAN	☐	Employee + Child(ren)	☐
		Employee +Family	☐
		Decline	☐

Legal - ARAG

Plan Type			
Employee Only	☐	Ultimate Advisor	☐
Employee + Family	☐	Ultimate Advisor Plus	☐

Decline

Dental - THE STANDARD

Plan Type			
Employee Only	☐	Low	☐
Employee + Spouse	☐	High	☐
Employee + Child (ren)	☐		
Employee +Family	☐		
Decline	☐		

Vision - VSP

Plan Type			
Employee Only	☐	Base	☐
Employee + Spouse	☐	Premier	☐
Employee + Child (ren)	☐		
Employee +Family	☐		
Decline	☐		

Virtual Health - RECURO

Plan Type	
Employee Only	☐
Employee +Family	☐
Decline	☐

Hospital Indemnity - AETNA

Plan Type			
Employee Only	☐	Base	☐
Employee + Spouse	☐	Buy-Up	☐
Employee + Child (ren)	☐		
Employee +Family	☐		
Decline	☐		

(Employer Paid Base Plan - Employee Only)

Medical Transport - MASA

Plan Type			
Employee Only	☐	Plus	☐
Employee +Family	☐	Premier	☐
Decline	☐		

Disability - THE HARTFORD

Short Term		Long Term	
7 Days	☐	60 Days	☐
14 Days	☐	90 Days	☐
30 Days	☐	180 Days	☐

Accident - AETNA

Plan Type			
Employee Only	☐	Base	☐
Employee + Spouse	☐	Buy-Up	☐
Employee + Child (ren)	☐		
Employee +Family	☐		
Decline	☐		

(Employer Paid Base Plan - Employee Only)

Cancer-AMERICAN FIDELITY ASSURANCE

Plan Type			
Employee Only	☐	Basic	☐
Employee + Spouse	☐	Enhanced	☐
Employee + Child (ren)	☐	Enhanced Plus	☐
Employee +Family	☐		
Decline	☐		

Critical Illness - AETNA

Plan Type			
Employee Only	☐	Low	☐
Employee + Spouse	☐	Mid	☐
Employee + Child (ren)	☐	High	☐
Employee +Family	☐		
Decline	☐		

Permanent Life - TEXAS Life

Employee ☐

Spouse ☐

Child (ren) ☐

Decline ☐

Group Life - THE STANDARD

Employee Coverage Amount

$_____

Decline ☐

*Optional Group Life - THE STANDARD

Amount

Optional Spouse Life $_____

Optional Child Life $_____

Decline ☐

Identity Theft Protection - ALLSTATE

Employee Only ☐

Employee +Family ☐

Decline ☐

Health Savings Account - EECU

Per Pay Day Amount

$_____

Decline ☐

Flexible Spending Account - FFGA

Per Pay Day Medical Amount

$_____

Per Pay Day Dependent Care Amount

$_____

To learn how to change your Beneficiary please visit the Smore news letter link below:
https://secure.smore.com/n/swk2m

BY SIGNING THIS FORM:

☐ **If enrolling- I understand that (1) My Social Security Benefits may be slightly reduced as a a result of this election. (2) My annual withholding (W-2) form will reflect my reducted 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 Benefit Plan. I understand that I will not be able to participate in the Flexible Benefit Plan until the enrollment for next plan year unless I have a qualifying circumstance in accordance with Internal Revenue Code Section 125.**

Employee Signature _____ **Date**_____