



# BENEFIT CHANGE FORM



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

### Employee Information

Legal First Name	MI	Legal Last Name	EP#	Position	Date of Birth	M / F
_____	_____	_____	_____	_____	_____	_____
(i.e. Elizabeth)		(i.e. Smith)		(i.e. 01/01/1970)		_____
Home Address	City	State	Zip Code	Preferred Phone Number		
_____	_____	_____	_____	_____		
Pay Frequency	Email Address	Employee Signature		Date Signed		
_____	_____	_____		_____		
<b>Check One:</b> Monthly        Semi-Monthly	_____					

I hereby 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.

### Change in Family Status

Instructions: Place your initials in the box for the status change you have experienced within the past 31 days and the date of the change:

Marriage	<input type="checkbox"/>	Date _____
Divorce	<input type="checkbox"/>	Date _____
Birth or Adoption	<input type="checkbox"/>	Date _____
Change in Job of Spouse	<input type="checkbox"/>	Date _____
Death	<input type="checkbox"/>	Date _____
Other	<input type="checkbox"/>	Date _____

### Dependent To Add or Drop

<u>Dependent Name</u>	_____	<u>Dependent Name</u>	_____
Date of Birth	_____ M / F _____	Date of Birth	_____ M / F _____
Relationship	_____	Relationship	_____
<u>Dependent Name</u>	_____	<u>Dependent Name</u>	_____
Date of Birth	_____ M / F _____	Date of Birth	_____ M / F _____
Relationship	_____	Relationship	_____

Circle One:    Adding Coverage    or    Dropping Coverage

<b>For Employee Benefits Department Use</b>	New Coverage Effective Date	Payroll Effective Date	Pay Frequency
_____	_____	_____	_____
Benefit Administrator Signature	Date Signed	_____	
_____	_____	_____	

# BENEFIT CHANGES

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Instructions: Place you initials in the box for the plan you wish to elect.

All Pre -Tax changes must correspond to a status change.

Select Your Plan		Select Your Coverage Category	
TRS ActiveCare Primary *	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>
TRS ActiveCare HD	<input type="checkbox"/>	Employee + Spouse	<input type="checkbox"/>
TRS ActiveCare Primary + *	<input type="checkbox"/>	Employee + Child(ren)	<input type="checkbox"/>
TRS ActiveCare 2 (No new enrollment allowed)	<input type="checkbox"/>	Employee + Family	<input type="checkbox"/>

Split Premium (Spouse with another TRS Health District)	<input type="checkbox"/>
Pool Premium (Lewisville ISD Spouse)	<input type="checkbox"/>
<b>Decline Medical</b>	<input type="checkbox"/>

\* PCP Code for Primary, Primary+ & HMO: \_\_\_\_\_

Cigna Low Dental Plan	Cigna High Dental Plan
Employee Only <input type="checkbox"/>	Employee Only <input type="checkbox"/>
Employee + Spouse <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>
Employee + Child(ren) <input type="checkbox"/>	Employee + Child(ren) <input type="checkbox"/>
Employee + Family <input type="checkbox"/>	Employee + Family <input type="checkbox"/>
<b>Decline Dental Plans</b> <input type="checkbox"/>	

Superior Vision
Employee Only <input type="checkbox"/>
Employee + Spouse <input type="checkbox"/>
Employee + Child(ren) <input type="checkbox"/>
Employee + Family <input type="checkbox"/>
<b>Decline Vision</b> <input type="checkbox"/>

EECU Health Savings Account	
Monthly Employee Amount	Annual Limit
\$ _____	\$ 4,300
Monthly Family Amount	
\$ _____	\$ 8,550
<b>Cancel / Decline H.S.A</b> <input type="checkbox"/>	

CHUBB Voluntary Employee Life
Employee Coverage \$ _____
<b>Cancel / Decline Employee Life</b> <input type="checkbox"/>

CHUBB Voluntary Spouse Life
Spouse Coverage \$ _____
<b>Cancel / Decline Spouse Life</b> <input type="checkbox"/>

**\* Note— Spouse and Child amount may not exceed 50% of Employee coverage and Employee coverage is required to elect Spouse and Child life coverage.**

**\* Spouse coverage can only be added in the event of a Marriage if Employee is currently enrolled in Unum Voluntary Employee Coverage.**

CHUBB Voluntary Child Life	
\$2,000	<input type="checkbox"/>
\$4,000	<input type="checkbox"/>
\$6,000	<input type="checkbox"/>
\$8000	<input type="checkbox"/>
\$10,000	<input type="checkbox"/>
<b>Cancel / Decline Dependent Life</b> <input type="checkbox"/>	

**\* Child coverage can only be added in the event of a Birth if Employee is currently enrolled in Unum Voluntary Employee Coverage.**

NBS Flexible Spending Accounts	
Monthly Dependent Care Amount \$ _____	Annual Limit \$5,000

**\* Dependent Care Spending coverage can only be added in the event of a Birth.**

**Decline Reimbursement Accounts**