



BENEFITS CHANGE FORM

Complete and return this form to the Benefits office within 30 days of status change.
Supporting documentation is required to complete your request.

Employee Last Name

First Name

DoB

QUALIFYING LIFE EVENT:

The change will be effective on the 1st of the month following the event date.

Birth

☐

Date of Event: _____

Change in Job Status of Spouse

☐

Marriage

☐

Divorce

☐

Medicare

☐

Other _____

☐

TRS MEDICAL COVERAGE (select your PLAN and COVERAGE)

TRS ActiveCare **Primary**

☐

Employee Only

☐

TRS ActiveCare **Primary +**

☐

Employee + Spouse

☐

TRS ActiveCare **HD**

☐

Employee + Children

☐

DECLINE Medical Coverage

☐

Employee + Family

☐

The **Primary** plans require a Primary Care Provider (PCP). To find a provider, please visit:
<https://www.bcbstx.com/trsactivecare/doctors-and-hospitals> and indicate the PCP ID below.

PCP ID: _____

PCP ID Pediatrician: _____

DEPENDENT TO ADD OR DROP:

1. Dependent's Name

2. Dependent's Name

Date of Birth & SSN (REQUIRED)

Date of Birth & SSN (REQUIRED)

3. Dependent's Name

4. Dependent's Name

Date of Birth & SSN (REQUIRED)

Date of Birth & SSN (REQUIRED)

BENEFITS CHANGE FORM

DENTAL COVERAGE

(For dental plan information, please visit <https://web.mybenefitshub.com/mansfieldisd>)

CIGNA Dental High ☐

CIGNA Dental Low ☐

CIGNA Dental HMO ☐

Employee Only ☐

Employee + Spouse ☐

Employee + Children ☐

Employee + Family ☐

DECLINE Dental Coverage ☐

VISION COVERAGE

(For vision plan information, please visit <https://web.mybenefitshub.com/mansfieldisd>)

DAVIS Vision ☐

Employee Only ☐

Employee + Spouse ☐

Employee + Children ☐

Employee + Family ☐

DECLINE Vision Coverage ☐

Enter additional comments: