BENEFIT CHANGE FORM

for a Qualifying Life Event (QLE)

LEWISVILLE ISD

Higginbotham Public Sector

- ***Complete Sections 1, 2 and 3 of this form electronically or manually.***
- ***Email this form with required supporting documentation to the Benefits Dept. at benefits@lisd.net.***

The Benefit Change Form and valid documentation must be received within 31 days of the Qualifying Life Event

Section 1 - Employee Information

Legal First Name _____ (i.e. Elizabeth)

MI _____

Legal Last Name _____ (i.e. Smith)

Employee # _____

Position _____

Date of Birth _____ (i.e. 01/01/1970)

M / F _____

Home Address _____

City _____

State _____

Zip Code _____

Preferred Phone Number _____

Pay Frequency

Check One: ☐ Monthly ☐ Semi-Monthly

Email Address _____

Employee Signature *(Electronic accepted)* _____

Date Signed _____

I acknowledge that: My requested benefit change is consistent with the QLE indicated and is being submitted within the required time-frame; failure to provide valid supporting documentation to verify this event may result in denial of the requested change; elections made will remain in effect for the rest of the plan year unless another QLE occurs.

Section 2 - Qualifying Life Event (QLE)

Check Add/Drop Coverage. Check Event and enter date.

☐ Add Coverage ☐ Drop Coverage

- *Marriage* ☐ Date _____
- *Divorce* ☐ Date _____
- *Birth (Birth Certificate Required)* ☐ Date _____
- *Employment Status Change* ☐ Date _____
- *Involuntary Loss of Coverage* ☐ Date _____
- *Other* _____ ☐ Date _____

Section 2a - Spouse/Dependent(s) To Add or Drop

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Additional Info: _____

For Employee Benefits Department Use

New Coverage Effective Date _____

Payroll Effective Date _____

Pay Frequency _____

Benefit Administrator Signature _____

Date Signed _____

Employee Name: _____

Section 3 - Benefit Changes

- **Place your initials in the box for the plan (and coverage tier) you are electing as a result of your change.**
- **Go to https://benefits.lisd.net to read about benefit plan details and rates.**
- **Only mark benefits being changed.**
- **Initial by "Drop" if waiving plan coverage.**

TRS ActiveCare Medical Plans

Initial Your Plan		Initial Your Coverage Tier			
TRS ActiveCare Primary **** PCP Required***	☐	Employee Only	☐	Split Premium (Spouse with another TRS Health District)	☐
TRS ActiveCare HD (High Deductible)	☐	Employee + Spouse	☐		
TRS ActiveCare Primary + **** PCP Required***	☐	Employee + Child(ren)	☐	Pool Premium (Lewisville ISD Spouse)	☐
TRS ActiveCare 2 (*No new enrollments*)	☐	Employee + Family	☐	***Drop Medical***	☐

****PCP ID #*** _____

To find your PCP ID# click on this link, https://www.bcbstx.com/trsactivecare/doctors-and-hospitals or call BCBS at 866-355-5999.

Cigna Low Dental Plan

- Low Employee Only ☐
- Low Employee + Spouse ☐
- Low Employee + Child(ren) ☐
- Low Employee + Family ☐

Drop Dental ☐

Cigna High Dental Plan

- High Employee Only ☐
- High Employee + Spouse ☐
- High Employee + Child(ren) ☐
- High Employee + Family ☐

EyeMed Vision

- Employee Only ☐
- Employee + Spouse ☐
- Employee + Child(ren) ☐
- Employee + Family ☐

Drop Vision ☐

EECU Health Savings Account - HD plans only

	Annual Limit*
Monthly Individual Amount $ _____	$4,400
Monthly Family Amount $ _____	$8,750

**Additional $1000 for age 55+*

Drop HSA ☐

NBS Dependent Care Flexible Spending Account

Monthly Dependent Care $ _____

Annual Limit $3,750/$7,500

Drop Dep. Care Account ☐

- **Dependent Care Account can only be added due to Birth.**
- **Changes in amount can only be made per Section 125 Plan rules. Contact the Benefits Dept for more info.**

CHUBB Voluntary Spouse Life

Spouse Coverage $ _____

Drop Spouse Life ☐

- **Spouse coverage can only be added due to Marriage, and**
- **Employee must be currently enrolled in Voluntary Life.**
- **Spouse coverage may not exceed Employee coverage.**

CHUBB Voluntary Child Life

- **Child coverage can only be added due to Birth, and**
- **Employee must be currently enrolled in Voluntary Life.**

$2,000	☐
$4,000	☐
$6,000	☐
$8,000	☐
$10,000	☐

Drop Dependent Life ☐

Comments: