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 ☐
Change in Job Status of Spouse ☐
Marriage ☐
Divorce ☐
Medicare ☐
Other _____ ☐

Date of Event: _____

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, visit: https://www.bcbstx.com/trsactivecare/doctors-and-hospitals and enter the **PCP ID** below. Use the Comments box for any additional PCP ID's.

PCP ID: _____

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	☐	Employee Only	☐
CIGNA Dental Low	☐	Employee + Spouse	☐
CIGNA Dental HMO	☐	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**: