HEB ISD
HURST-EULESS-BEDFORD

QUALIFYING EVENT FORM
2026-2027 PLAN YEAR

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME (LEGAL NAME)	HEB ID#

EMAIL ADDRESSS	CONTACT #

QUALIFYING EVENT REASON

DEPENDENT INFORMATION (COMPLETE IF ADDING COVERAGE)

First and Last Name	DATE OF BIRTH	SSN (REQUIRED)	GENDER	DISABLED?
EMPLOYEE				
SPOUSE				☐ YES ☐ NO
CHILD #1				☐ YES ☐ NO
CHILD #2				☐ YES ☐ NO
CHILD #3				☐ YES ☐ NO
CHILD #4				☐ YES ☐ NO

First Name Only	BENEFITS	COVERAGE ACTION
EMPLOYEE	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Critical Illness ☐ Hospital Ind.	☐ ADD ☐ REMOVE
SPOUSE	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Critical Illness ☐ Hospital Ind.	☐ ADD ☐ REMOVE
CHILD #1	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Critical Illness ☐ Hospital Ind.	☐ ADD ☐ REMOVE
CHILD #2	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Critical Illness ☐ Hospital Ind.	☐ ADD ☐ REMOVE
CHILD #3	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Critical Illness ☐ Hospital Ind.	☐ ADD ☐ REMOVE
CHILD #4	☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Critical Illness ☐ Hospital Ind.	☐ ADD ☐ REMOVE

Acknowledgement

I understand that if I voluntarily drop coverage in the middle of the plan year for myself, my dependents, and/or spouse, I will **NOT** be able to re-enroll until another qualifying event occurs. I understand I will need to provide the supporting documentation necessary to prove my status change to the benefits office within 30 days of the qualifying event date.

Section 125 Acknowledgement

I understand I am automatically enrolled to participate in SECTION 125 for all benefits. I understand that if I elected to participate in the flexible spending plan any funds that have not been used by the end of the plan year CANNOT be returned to me. I must "**use it or lose it**." I understand that I cannot change any tax benefits before the next anniversary date except for a Qualifying Event Change. I further understand that any before-tax elections shall remain in effect from year to year until I cancel them. I understand that I may cancel my election participation only during the annual open enrollment period unless I cancel my participation due to a change in family status.

Electronic Signature Acknowledgment

By typing my full name below, I certify that the information provided is accurate and that my electronic signature is legally binding and equivalent to my handwritten signature.

Electronic Signature: _____ Date: _____

THE RATES SHOWN ARE PER PAYCHECK.

ACTIVECARE PRIMARY		ACTIVECARE PRIMARY+		ACTIVECARE HD (PPO)	
EMP ONLY	☐ $156.00	EMP ONLY	☐ $210.00	EMP ONLY	☐ $165.00
EMP+SPOUSE	☐ $676.50	EMP+SPOUSE	☐ $786.00	EMP+SPOUSE	☐ $700.50
EMP+CHILD(REN)	☐ $370.50	EMP+CHILD(REN)	☐ $462.00	EMP+CHILD(REN)	☐ $385.50
FAMILY	☐ $890.50	FAMILY	☐ $1,270.50	FAMILY	☐ $921.00
PCP#		PCP#		NO PCP REQUIRED	

HEALTH SAVINGS ACCOUNT ☐ NO CHANGE

(COMPLETE ONLY IF YOU ENROLLED FOR AC HD MEDICAL PLAN) MAX: $179.16 (EMP ONLY) | $356.25 (FAM)

☐ CANCEL MY HSA ☐ ENROLL $ ☐ CHANGE TO $

CIGNA DENTAL	PPO – HIGH PLAN		PPO – LOW PLAN		DENTAL HMO	
☐ NO CHANGE	EMP	☐ $23.15	EMP	☐ $15.12	EMP	☐ $7.56
	EMP+1	☐ $45.99	EMP+1	☐ $31.14	EMP+1	☐ $14.36
	FAMILY	☐ $69.75	FAMILY	☐ $42.03	FAMILY	☐ $22.67

HOSPITAL INDEMNITY ☐ NO CHANGE

PLAN 1		PLAN 2	
EMP	☐ $7.69	EMP	☐ $15.38
EMP+SP	☐ $15.43	EMP+SP	☐ $30.85
EMP+CH	☐ $11.49	EMP+CH	☐ $22.97
FAMILY	☐ $19.22	FAMILY	☐ $38.44

DISABILITY

☐ CANCEL MY DISABILITY POLICY
If you have an open claim, you cannot cancel your policy until open enrollment.

CRITICAL ILLNESS ☐ NO CHANGE

	$10,000	$20,000	$30,000	$40,000
EMP				
EMP+CH				
EMP+SP				
FAMILY				

SUPERIOR VISION

EMP	☐ $3.52
EMP+1	☐ $6.83
FAMILY	☐ $10.02
☐ NO CHANGE	

VOLUNTARY LIFE INSURANCE ☐ NO CHANGE

EMP	☐ ADD $	(Amount of Coverage) @ $	per paycheck
SPOUSE	☐ ADD $	(Amount of Coverage) @ $	per paycheck
CHILD(REN)	☐ ADD $10,000 per child @ $0.60 per paycheck		

FLEXIBLE SPENDING ACCOUNT (FSA and DCA) ☐ NO CHANGE

MAX: FSA $112.50 | DEPENDENT CARE $208.33 per paycheck (*You cannot cancel if you have withdrawn more than your annual contribution*)

FSA	☐ ENROLL $	per paycheck	☐ CHANGE TO $	☐ CANCEL
DAY CARE	☐ ENROLL $	per paycheck	☐ CHANGE TO $	☐ CANCEL