BIRDVILLE ISD BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE: _____

Employee Name (First, Middle, Last)			**Title/Position**	**Employee ID#**
Campus ID#	**Work Phone Number**	**Home Phone Number**	**Date of Birth**	**Pay Period** ☐ **12 Pay** ☐ **26 Pay**

REASON FOR REQUEST

You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Benefits Department within 31 days of the change. Proof of change is required.

CHECK REASON FOR CHANGE

☐ Marriage ☐ Divorce ☐ Birth/Adoption of a child/Gains legal guardianship ☐ Death of spouse or dependent ☐ Dependent becomes eligible ☐ Dependent becomes ineligible

☐ Loss of other qualified group coverage ☐ Spouse changes employment - Gains Coverage ☐ Spouse changes employment - Loses Coverage ☐ Other - Explain_____

COMPLETE CHART WITH CHANGES RELATIVE TO THE QUALIFIED EVENT

COVERAGE	☐ **Add** ☐ **Remove**	**Plan Level or Amount**
Medical	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	☐ **Plan 1 HD** ☐ **Plan 2** ☐ Select Plan ☐ HMO
Medlink Medical Gap Plan	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	
Dental	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	☐ **DMO** ☐ **High PPO** ☐ **Low PPO**
Vision	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	
Cancer	☐ **Employee** ☐ **Employee + Child(ren)** ☐ **Employee + Family**	☐ **High Option Basic Plan** ☐ **Basic + ICU Rider** ☐ **Low Option Basic Plan** ☐ **Basic + ICU Rider**
Disability	☐ **Employee**	**Waiting Period** **Monthly Coverage $**
Voluntary Group Life	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)**	**EE $** **SP $** **CH $10,000**
Medical Reimbursement (circle one) FSA or HSA	☐ **Employee**	**Amount Per Pay Period $**
Dependent Care Reimbursement	☐ **Employee**	**Amount Per Pay Period $** **Annual Max $5,000**
Identity Theft Protection	☐ **Employee** ☐ **Employee + Family**	
Accidental Death & Dismemberment	☐ **Employee** ☐ **Employee + Family**	
MetLaw (legal services)	☐ **Employee**	

COVERED FAMILY MEMBERS INFORMATION

If adding a qualified family member, you must complete all family member information requested. If changing coverage, only list the member(s) with the qualified change.

SPOUSE_____DATE OF BIRTH_____SSN_____ ☐ **Male** ☐ **Female**

CHILD_____DATE OF BIRTH_____SSN_____ ☐ **Male** ☐ **Female**

CHILD_____DATE OF BIRTH_____SSN_____ ☐ **Male** ☐ **Female**

CHILD_____DATE OF BIRTH_____SSN_____ ☐ **Male** ☐ **Female**

For Benefits Department Use:

☐ Accepted ☐ Denied

Date Received _____

Entered in Benefits Hub: _____

Important: I understand and have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand that the above selections may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I also understand that changes resulting in the addition of coverage will be effective the 1st day of the month following the qualifying event. I will be responsible for paying back any missed premiums. If dropping coverage, the effective date will be the 1st of the month following the signature date.

Signature _____ Date _____

Please fax completed form and supporting documentation to the Benefits Office at 817-831-5721