BENEFIT CHANGE FORM

Complete and return this form to the Benefit Dept. within 31 days of a status change

Employee Information

Legal First Name _____ MI ____ (i.e. Elizabeth)

Legal Last Name _____ (i.e. Smith) EP# _____

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

Home Address _____

City _____ State ____ Zip Code ____

Home / Cell Preferred Phone Number ( ) _____

Work Phone Number ( ) _____ Ext.

Email Address _____

Change in Family Status

Instructions: Place your initials in the box for the status change you have experienced within the past 31 days and the date of the change:

Marriage	☐	Date _____
Divorce	☐	Date _____
Birth or Adoption	☐	Date _____
Change in Job of Spouse	☐	Date _____
Death	☐	Date _____
Other	☐	Date _____

Dependent 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 _____

Payroll Information

For Employee Benefits Department Use

New Coverage Effective Date _____

Payroll Effective Date _____

Pay Frequency _____

I hereby certify that the above information is true and correct to the best of my knowledge and that evidence of the above events must be submitted to the Plan Administrator. I understand that Change in Family Status is subject to validation and approval of Administrator.

Employee Signature _____ Date Signed _____

Benefit Administrator Signature _____ Date Signed _____

BENEFIT CHANGES

FIRST NAME: _____ **LAST NAME:** _____

Instructions: Place you initials in the box for the plan you wish to elect.

All Pre -Tax changes must correspond to a status change.

TRS MEDICAL COVERAGE

Select Your Plan		Select Your Coverage Category	
TRS ActiveCare Primary	☐	Employee Only	☐
TRS ActiveCare HD	☐	Employee + Spouse	☐
TRS ActiveCare Primary +	☐	Employee + Child(ren)	☐
TRS Central and North TX Scott and White HMO	☐	Employee + Family	☐
TRS ActiveCare 2 (No new enrollment allowed)	☐		

Split Premium (Spouse with another TRS Health District) ☐

Pool Premium (Lewisville ISD Spouse) ☐

Decline Medical ☐

PCP Code for Primary, Primary+ & HMO: _____

METLIFE STANDARD DENTAL PLAN

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

METLIFE BASIC DENTAL PLAN

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

Decline Dental ☐

UNITED HEALTHCARE VISION

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

Decline Vision ☐

LEGALEASE LEGAL SERVICES

Family Coverage ☐

Decline Legal ☐

CIGNA DISABILITY PROTECTION

Elimination Period

- 14 Days ☐
- 30 Days ☐
- 90 Days ☐
- 60 Days ☐

Monthly Benefit Amount $ _____

Benefit Duration

- 5 Years (Select) ☐
- SSNRA* ☐

Cancel / Decline Disability ☐

Please Note: Cancelling Life or Disability coverage will make you and/or your Dependents subject to underwriting guidelines and possible denial if you apply for coverage at Lewisville ISD in the future.

* SSNRA is the Social Security Normal Retirement Age

AFLAC HOSPITAL INDEMNITY

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

Cancel / Decline Cancer ☐

MASA EMERGENT PLUS PLAN

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

Cancel / Decline MASA ☐

UNUM VOLUNTARY EMPLOYEE LIFE

Employee Coverage $ _____

Cancel / Decline Employee Life ☐

UNUM VOLUNTARY SPOUSE LIFE

Spouse Coverage $ _____

Cancel / Decline Spouse Life ☐

UNUM VOLUNTARY CHILD LIFE

- $2000 ☐
- $4000 ☐
- $6000 ☐
- $8000 ☐
- $10,000 ☐

Cancel / Decline Dependent Life ☐

**** Note– Spouse and Child amount may not exceed 50% of employee coverage and Employee coverage is required to elect Spouse and Child life coverage.***

CIGNA CRITICAL ILLNESS

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

Cancel / Decline CI ☐

Benefit Amount

- $10,000 ☐
- $20,000 ☐
- $30,000 ☐

Note– Spouse and Child coverage is 100% of employee elected amount.

NBS FLEXIBLE SPENDING ACCOUNTS

	Annual Limit
Per Pay Day Medical Amount $ _____	$ 2,750
Per Pay Day Dependent Care Amount $ _____	$ 5,000

Decline Reimbursement Accounts ☐

EECU HEALTH SAVINGS ACCOUNT

	Annual Limit
Per Pay Day Employee Amount $ _____	$ 3,600
Per Pay Day Family Amount $ _____	$ 7,200
Annual 55+ Catchup Amount $ _____	

Cancel / Decline H.S.A ☐

**** You must designate a Primary Beneficiary and/or Contingent Beneficiary***