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 _____ Legal Last Name _____ EP# _____ Position _____ Date of Birth _____ M / F _____

(i.e. Elizabeth) (i.e. Smith) (i.e. 01/01/1970)

Home Address _____ City _____ State _____ Zip Code _____ Preferred Phone Number _____

Pay Frequency _____ Email Address _____ Employee Signature _____ Date Signed _____

Circle One: Monthly or Semi-Monthly

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.

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 _____

Circle One: Adding Coverage or Dropping Coverage

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 _____

For Employee Benefits Department Use

New Coverage Effective Date _____ Payroll Effective Date _____ Pay Frequency _____

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 Plans ☐

UNITED HEALTHCARE VISION

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

Decline Vision ☐

EECU HEALTH SAVINGS ACCOUNT

Monthly Employee Amount	Annual Limit
$ _____	$ 3,600
Monthly Family Amount	
$ _____	$ 7,200

Cancel / Decline H.S.A ☐

UNUM VOLUNTARY EMPLOYEE LIFE

Employee Coverage $ _____

Cancel / Decline Employee Life ☐

UNUM VOLUNTARY SPOUSE LIFE

Spouse Coverage $ _____

Cancel / Decline Spouse Life ☐

*** Spouse coverage can only be added in the event of a Marriage if Employee is currently enrolled in Unum Voluntary Employee Coverage.**

UNUM VOLUNTARY CHILD 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.***

- $2,000 ☐
- $4,000 ☐
- $6,000 ☐
- $8000 ☐
- $10,000 ☐

Cancel / Decline Dependent Life ☐

*** Child coverage can only be added in the event of a Birth if Employee is currently enrolled in Unum Voluntary Employee Coverage.**

NBS FLEXIBLE SPENDING ACCOUNTS

Monthly Dependent Care Amount	Annual Limit
$_____	$5,000

*** Dependent Care Spending coverage can only be added in the event of a Birth.**

Decline Reimbursement Accounts ☐