BENEFIT CHANGE FORM

Section 1 – Employee Information

I have a qualifying Life event: ☐ Marriage ☐ New Child ☐ Divorce ☐ Loss of Coverage ☐ New Hire

Desoto ISD		Effective date for changes:			
Employee Name:		Social Security Number:		Date of Birth:	
Annual Salary:	Gender:	Hire Date:	Campus Location:		
Mailing Address (Street Apt):		City	State	Zip	
Home Phone Number:		Email:			

Section 2 – Family Information

Dependent Name	Date of Birth	Gender	SS Number	Beneficiary (% must total 100%)	
				Primary	Contingent
Spouse					
Child					
Child					
Child					
Child					

Section 3 – Benefit Election YOU MUST CHECK ALL WAIVED BENEFITS PLEASE

TRS BCBS Medical: Pre-Tax ☐ **Waive**

☐ **ActiveCare Primary** ☐ **ActiveCare HD**

☐ **ActiveCare Primary +** ☐

☐ Employee Only ☐ Employee & Spouse

☐ Employee & Children ☐ Employee &Family

Primary/Primary+ Must provide PCP Name & PHI Number:_____

https://www.bcbstx.com/trsactivecare/doctors-and-hospitals

Flexible Savings Account (FSA)

☐ **Waive**

☐ Individual Coverage (*Maximum Annual Amount - $3,400)*

$_____ Annual Contribution

You cannot enroll into a FSA plan if you are currently enrolled into a HSA plan.

Health Savings Account Pre-Tax

☐ Waive

Annual Contribution:

$_____

Maximum contributions:

Individual - $4,400

Family - $8,750

*NEW ENROLLEES MUST PROVIDE DL#_____

Ameritas Vision: (Pre-tax)

☐ **Waive**

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Children

☐ Employee & Family

Ameritas Dental: (Pre-tax)

☐ Waive

☐ Enhanced ☐ Basic

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Children

☐ Employee &Family

Recuro Telehealth: (Pre-tax)

☐ **Waive**

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Children

☐ Employee & Family

Wellfleet Accident: (Pre-tax)

☐ Waive

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Children

☐ Employee &Family

Wellfleet Critical Illness: (Pre-tax)

☐ **Waive**

☐ Tobacco ☐ non-Tobacco

☐ Employee

☐ Employee & Family

Coverage Amount $_____

The Standard Disability: (After-Tax)

☐ **Waive**

Elimination Period:

☐ 7 Day ☐ 14 Day ☐ 30 Day

☐ 60 Day ☐ 90 Day

Monthly Benefit Amount:_____

MASA Medical Transport:

☐ **Waive**

☐ Emergent Plan ☐ Platinum Plan

☐ Employee

☐ Family

Texas Life ☐ **Waive**

☐ Employee Coverage $_____

☐ Spouse Coverage $_____

☐ Child(ren) $25,000 or $50,000

AFA Life ☐ **Waive**

☐ Employee Coverage $_____

☐ Spouse Coverage $_____

☐ Child(ren) $25,000 or $50,000

This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status. I understand that I have verified the benefits elected above and authorize any payroll deductions required for those elections.

Employee Signature: x_____

Date: _____/_____/_____

***When you have completed this form, please return it to Crystal Reed, crystal.reed@desotoisd.org**

Please review all benefits available to Desoto ISD employees at: https://benefits.ffga.com/desotoisd/