ALLEN ISD BENEFITS CHANGE FORM

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 30 days of the change. Verifiable documentation of the qualifying event must be provided in order for the request to be processed. Your request will be denied if you fail to notify the Benefits Office within 30 days. Change in election must be related to the reason for the change. Complete "Covered Family Members" section with the names of family members to be added or canceled.

Employee Name (Last, First, Middle)	**Employee ID Number**	**Social Security Number** (if Employee ID is unknown)
Phone Number	**Email Address**	**Qualified Life Event Date**

Note: This form must be received by AISD Benefits Office within 30 days of the event.

Enroll/Add/Change

- ☐ Birth/Adoption
- ☐ Marriage/Civil Union
- ☐ Other AISD Qualified Event

Spouse's name (if employed by AISD):

- ☐ COBRA Qualifying Events
- ☐ Divorce
- ☐ Involuntarily Lost Coverage
- ☐ Legal Guardianship
- ☐ Judgment, Decree or Order
- ☐ Other:

Delete/Cancel

- ☐ Death of Dependent
- ☐ Dependent newly eligible for own benefits due to job commencement, job change or their employer's open enrollment.
- ☐ Medicare, Medicaid or CHIP eligibility
- ☐ Cancel coverage for me and my dependents.

Reason: _____

Complete chart with changes relative to the qualified event information employee is providing.

Medical

☐ Add ☐ Change ☐ Drop

☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family

☐ BSWHP
☐ ActiveCare HD
☐ ActiveCare Primary
☐ ActiveCare Primary+

Dental

☐ Add ☐ Change ☐ Drop

☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family

☐ Ameritas Hybrid
☐ Ameritas Low
☐ Ameritas High

Vision

☐ Add ☐ Change ☐ Drop

☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family

Hospital Indemnity

☐ Add ☐ Change ☐ Drop

☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family

☐ MetLife Low $1000
☐ MetLife Mid $2000
☐ MetLife High $3000

Flexible Spending Account

☐ Add ☐ Change ☐ Drop

Medical FSA
$ _____ /pay period
(Annual Max $2,850)

Dependent Care Account
$ _____ /pay period
(Annual Max $5,000)

Covered Family Members Information

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

Employee Info				PCP Name (Primary & Primary+ plans)	PCP ID
Spouse Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		

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 Department within 30 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.

Employee Signature _____ Date _____

For Benefits Dept use:	☐ *Accepted* ☐ *Denied*	*Date Received:*	*Date Entered:*	*Date Effective:*

Please fax or email completed form and supporting documentation to the Benefits Office at 972-727-0496 / benefits@allenisd.org updated 9/1/22