BENEFIT ELECTION/CHANGE FORM

☐ New Hire Enrollment ☐ Qualifying Event

Section 1 - Life Event Change (Only complete if qualifying event) Pre-Tax Insurance

You may make elections changes during the Section 125 Plan Year if you have a qualifying event and you notify the Benefits Department within 31 days of the event. Please complete all information.

Reason for request: ☐ Marriage / Divorce ☐ Death of a Spouse or Dependent ☐ Birth or Adoption of a Child ☐ Loss of Coverage

☐ Job Status Change for Employee ☐ Termination/Commencement of Spouse's Employment

☐ Other (Please Explain):_____ **Effective Date of Change:**____/____/____

Section 2 – Employee Information (*Please Print*)

Employee Name:			Social Security Number	Date of Birth:
Gender:	Marital Status:	Phone Number:	Email address:	
Mailing Address:				
Physical Address *(required if mailing address is PO Box)*:				

For the Benefits Department use only:

Annual Salary: $	Hire Date:	Occupation:	Location:
Hours worked:	Pay Frequency: __12 ___20 ___26	Effective Date:	Benefits Termination Date:

Section 3 – Family Information (*Please Print)*

Dependent Name	SSN	DOB	M/F	Add or Drop
Spouse				
Child				
Child				
Child				
Child				

Section 4 – Benefit Selection (*Please indicate election by using an "X")*

TRS Medical Pre-Tax ☐ Decline

☐ Activecare HD ☐ Primary Plan ☐ Primary +

☐ Employee Only ☐ Employee & Child(ren)

☐ Employee & Spouse ☐ Employee & Family

*PRIMARY AND PRIMARY + MUST PROVIDE PCP INFO BELOW:

PCP Name: _____

PCP-PHI NUMBER_____

(STARTS WITH A LETTER "H")

Flexible Spending Accounts Pre-Tax ☐ Decline

☐ Medical Reimbursement (*Maximum Annual Amount - $3400)*

$_____ Annual Contribution

☐ Dependent Care Reimbursement (*Maximum Annual Amount - $5,000)*

$_____ Annual Contribution

Health Savings Account Pre-Tax ☐ Decline

Annual Contribution: $_____

Maximum contributions: Individual - $4,400/Family - $8,750

*NEW ENROLLEES MUST PROVIDE DL#_____

Standard Disability Post-Tax ☐ Decline **Elimination Period:** ☐ 7 Day ☐ 14 Day ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day Monthly Benefit Amount: $_____ Monthly Premium: $_____	**Ameritas Dental** Pre-Tax ☐ Decline ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Employee & Family	**EyeMed Vision** Pre-Tax ☐ Decline ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Employee + Family
TEXAS LIFE INSURANCE Post-Tax ☐ Decline ☐ Employee $_____ ☐ Spouse $_____ ☐ Child(ren) $25,000 or $50,000	**Aetna Critical Illness** Post-Tax ☐ Decline ☐ $10,000 ☐ $20,000 ☐ Employee ☐ Spouse ☐ Child(ren)	**Lincoln Gp Term Life** Post-Tax ☐ Decline ☐ Employee Coverage $_____ ☐ Spouse Coverage $_____ ☐ Child(ren) $10,000
Standard Accident Post-Tax ☐ Decline ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee & Family	**Guardian Cancer Plan** Post-Tax ☐ Decline ☐ Employee ☐ Employee & Child(ren) ☐ Employee & Family	**Aura Identity Theft** Post-Tax ☐ Decline ☐ Protection ☐ Protection Plus ☐ Employee ☐ Employee & Family
Recuro Telehealth Post-Tax ☐ Decline ☐ Employee ☐ Employee & Family	**Aetna Hospital Indemnity** Post-Tax ☐ Decline ☐ Low Plan ☐ High Plan ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Employee + Family	**MASA Medical Transport** Post-Tax ☐ Decline ☐ Platinum Plan ☐ Emergent Plan ☐ Employee ☐ Employee & Family

Section 5 – Beneficiary Designation (*Please Print*)

Primary Beneficiary: Name_____ Date of Birth_____ Relationship_____ Percentage_____	**Contingent Beneficiary:** Name_____ Date of Birth_____ Relationship_____ Percentage_____

Section 6 - Signatures

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: _____/_____/_____

Benefits Administrator Signature: x_____ Date: _____/_____/_____