Italy Independent School District

- **Review benefits.ffga.com/italyisd before making your benefit selections.**
- **New employees** have 31 days from their hire date to enroll in benefits.
- **All employees** have 31 days to change benefits upon Qualifying Life Events (from date of event).
- **All employees receive $10K in Group Life Insurance and WellVia Telemedicine provided by Italy ISD.**

Section 1 – Employee Information **Print Legibly**

Employer:	Plan Year:	☐ New Hire Enrollment ☐ Qualifying Event ☐ Termination ☐ COBRA			
Italy ISD	2020 - 2021	Termination Date _____ Date of first/last deduction _____ Employee #_____			
Employee Name:		Social Security Number:		Date of Birth:	
Annual Salary:	Gender:	Hire Date:	Payroll Frequency: 12 24		Location Working:
Mailing Address (Street Apt):			Marital Status:		Occupation:
City:		State:	Zip Code:	Home Phone Number:	
Work Email: @italyisd.org		Year graduated high school:			

Section 2 – Change in Elections due to Life Event

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

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

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

Section 3 – Family Information **This section must be completed regardless if family members are covered under insurance.**

Dependent Name	Date of Birth	Gender M/F	Disabled Y/N	Spouses Occupation or Full-Time Student	Social Security Number MUST BE PROVIDED DO NOT LEAVE BLANK	Flexible Spending Account Debit Card? (if enrolling) Y/N
Spouse						
Child						
Child						
Child						
Child						
Child						

Section 4 – Beneficiary Information **This section must be completed for group life insurance and other voluntary life insurance.**

Full Name		Date of Birth	Gender M/F	Relationship to Insured	Group Life Voluntary Group Life Texas Life
Primary					
Contingent					

Section 5 – Benefit Election

TRS Medical ☐ Pre-Tax ☐ After-Tax ☐ **Waive *Declination Required***

☐ ActiveCare HD ☐ ActiveCare Primary ☐ ActiveCare Primary Plus

☐ Scott & White

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee &Family

Ameritas Dental (Pre-tax) ☐ **Waive**

☐ Employee Only
☐ Employee + One
☐ Employee & Family

Ameritas Vision (Pre-tax) ☐ **Waive**

☐ Employee Only
☐ Employee + One
☐ Employee & Family

AFA Disability (After-Tax) ☐

Waive

Elimination Period:

☐ 14 Day ☐ 30 Day ☐ 60 Day

☐ 90 Day ☐ 150 Day

Monthly Benefit Amount:

$_____

AFA Accident (Pre-tax) ☐ **Waive**

☐ **Basic** ☐ **Enhanced**
☐ Employee Only
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Employee & Family

Premium: $_____

BlueCross BlueShield Group Life (After-tax) ☐ **Waive**

☐ Employee Coverage $_____

Monthly Premium $_____

☐ Spouse Coverage $_____

Monthly Premium $_____

☐ Child(ren)Coverage$10,000

Monthly Premium $_____

Allstate Critical Illness ☐ **Waive**

☐ **Non-Tobacco** ☐ **Tobacco**
☐ **Low Plan** ☐ **High Plan**

☐ Employee Only
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Employee & Family

Legal Shield / Identity Protection

☐ **Waive**

☐ **Employee Only**

☐ **Employee + Family**

☐ ID Shield
☐ Legal Shield
☐ Legal Shield w/ ID Shield

Texas Life Insurance (After-tax) ☐ **Waive**

☐ Employee $_____
☐ Spouse $_____
☐ Children $_____ $50,000 (max)

☐ **Non-Tobacco**
☐ **Tobacco User**

Has the Proposed Insured been actively at work on a full time basis for the past 6 months performing usual job duties? If no, provide details on separate sheet.

☐ Yes ☐ No

Has the Proposed Insured been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days within the past 6 months? If yes, provide details on separate sheet.

☐ Yes ☐ No

Has the Proposed Insured been disabled; received treatment or care in a hospital or hospice, or in a custodial, intermediate skilled nursing care or long-term care facility; received chemotherapy, radiation therapy or dialysis treatment; received treatment in a hospital or rehabilitation center for alcohol or drug abuse within the last 6 months? If yes, provide details.

☐ Yes ☐ No

Flexible Spending Account (Pre-tax) ☐ **Waive**

$_____ Monthly

$_____ Annual

How many Debit Cards_____ List the name of each card holder below:

1. _____
2. _____
3. _____

***Maximum contribution for your flexible spending account is $2550.00 and $5000.00 maximum for dependent care contributions.**

Dependent Care Reimbursement (Pre-tax) ☐ **Waive**

$_____ Monthly

$_____ Annual

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:** _____/_____/_____

* Upon completion of this form return to your benefits office **ddearing@italyisd.org or chris.hunter@ffga.com ***