## **Desoto Independent School District**



- Review benefits.ffga.com/desotoisd before making your benefit selections.
- All employees have 30 days to change benefits upon Qualifying Life Events (from date of event).
- View Life Event Qualifications https://www.irs.gov/pub/irs-regs/td8878.pdf.

ee Information Pl	Till Legibly	□ Mas	ıı Hino Erre	llmont	Ouglifying Front	. Dr.	mmination D	CODDA	
Pian Year:		_							
								duction Employee #	
Employee Name:			Social Security Number:				Date of Birth:		
Annual Salary: Gender:			ate:		Payroll Frequency: 12 24		Location Working:		
Mailing Address (Street Apt ):					Marital Status:		Occupation:		
City:				Zip Co	ode: Home Pho		one Number:		
Work Email:			desotoisd.org Year graduated hig			şh school:			
elections change of the event. Plea	s during the Se se complete all	l information a	and return	this form	along with suppor	rting docu	mentation of th		
			-	-	-				
Explain):						Effe	ctive Date of Ch	ange: <u>/</u> /	
nformation This	section must	be complete	d regardl	ess if far	nily members are	e covered	under insura	nce.	
ependent Name		Date of Birth	Gender M/F	Disabled Y/N	or	MUST	Number BE PROVIDED	Flexible Spending Account Debit Card? (if enrolling)  Y/N	
								1/10	
ion, Information 7	This soction m	ust be some	lated for	group lif	o incurance and	othor vol	untary life inc	uranco	
						other von	Group Life		
run Name		Birth	M/F			Voluntary Group Life Texas Life			
	Plan Year:	Plan Year:  Gender:  Street Apt ):  in Elections due to Life Event elections changes during the Se of the event. Please complete al st: Marriage / Divorce Job Status Change fo Explain):  Information This section must ependent Name  ary Information This section must	Plan Year:  Gender:  Gender:  Hire Date of Birth  Termin Social:  Gedesotoi  in Elections due to Life Event elections changes during the Section 125 Plan f the event. Please complete all information ast:  Marriage / Divorce Death of a standard Date of Birth  Date of Birth  Date of Birth  This section must be complete ependent Name  Date of Birth  Date of Birth  Date of Date of Birth	Plan Year:    New Hire Enro     Termination Date     Social Security Nu     Gender:   Hire Date:     State:     @desotoisd.org     in Elections due to Life Event     elections changes during the Section 125 Plan Year if you of the event. Please complete all information and return     st:	Plan Year:    Rew Hire Enrollment     Termination Date     Social Security Number:    Gender:   Hire Date:	Plan Year:	Plan Year:	Plan Year:	

Section 5 – Benefit Election										
TRS Medical ☐ Pre-Tax ☐ After-Tax	□Waive	Ar	] Waive							
	Baylor Scott & White									
☐ Employee Only ☐ Employee & Spouse ☐ En	nployee & Children LEmployee & Family	Employee & Family								
Premium: \$		Pre								
Ameritas Vision(Pre-tax) ☐ Waive	AFA Disability(After-Tax)  ☐ Waiv		AFA Accident(Pre-tax)							
☐ Employee Only ☐ Employee & Spouse	Elimination Period:		☐ Waive							
☐ Employee & Children	☐ 14 Day ☐ 30 Day ☐ 60 Day		☐ Employee & Spouse							
☐ Employee & Family	□90 Day □150 Day		Employee & Child(ren)							
Premium: \$	Monthly Benefit Amount: \$		Employee & Family Premium: \$							
Dearborn Group Life (After-tax)	Allstate Cancer (After-tax)	•	Allstate Heart & Stroke (After-tax)							
_ ☐ Waive	☐ Basic ☐ Enhanced ☐ Premier	Waive	☐ Low Plan ☐ High Plan	☐ Waive						
Employee Coverage \$	☐ Non-Tobacco ☐ Tobacco		□ Non-Tobacco □ Tobacco							
Monthly Premium \$										
☐ Spouse Coverage \$	☐ Employee Only ☐ Employee & Family		☐ Employee Only ☐ Employee & Family							
Monthly Premium \$	<u> </u>									
☐ Child(ren)Coverage <u>\$10,000</u> Monthly Premium \$	Premium: \$	Premium: \$								
AFLAC Critical Illness	☐ Waive	ı	□ Non-Tobacco □ Tobacco							
Benefit Amount: \$	Premium Amount: \$									
Texas Life Insurance(After-tax)	□ Waive	Flexi	ble Spending Account(Pre-tax)	☐ Waive						
Employee \$	□ Non-Tobacco	\$								
☐ Spouse \$ \$50,000 (m	☐ Tobacco User	\$								
Has the Proposed Insured been actively at work or performing usual job duties? If no, provide details  Yes No	·	How m	any Debit Cards List the name of each card holder below:							
Has the Proposed Insured been absent from work period of more than 5 consecutive working days w details on separate sheet.  Yes No		Maximum contribution for your flexible spending account is \$2550.00 and \$5000.00 maximum for dependent care contributions.								
Has the Proposed Insured been disabled; received or in a custodial, intermediate skilled nursing care chemotherapy, radiation therapy or dialysis treatmentabilitation center for alcohol or drug abuse with	or long-term care facility; received ent; received treatment in a hospital or	Dependent Care Reimbursement (Pre-tax)								
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 benefitsdepartment@desotoisd.org\*