First Financial Group of America
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BENEFIT ELECTION/CHANGE FORM

☐ New Hire Enrollment ☐ Qualifying Event ☐ Termination

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. **Review benefits.ffga.com/paradiseisd before making your benefit selections.**

- **New employees** have 31days 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 full time employees** are given employer paid term life insurance amount based on employee age.

Documentation is required for a qualifying life event to occur.

Examples: Copy of marriage/death/birth certificate, a letter from previous employer stating that coverage is ending.

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 or Spouse ☐ 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:	Work Email Address: @pisd.net	
Mailing Address				Year Graduated High School
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 ____24	Effective Date:	Termination Date:
Employee ID Number			

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

Dependent Name	Social Security Number MUST BE PROVIDED DO NOT LEAVE BLANK	Date Of Birth	Disabled Y/N	M/F
Spouse				
Child				
Child				
Child				
Child				

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

TRS Medical **Pre-Tax** ☐ Decline

Effective: ☐ Actively at Work Date ☐ First day of month following

☐ Activecare 1-HD ☐ Activecare Select ☐ Activecare 2

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

Please Circle

Have you used tobacco in any form in the last 3 months? Yes Or No

Has your spouse used tobacco in any form in the last 3 months?

Yes Or No

Flexible Spending Accounts **Pre-Tax** ☐ Decline

☐ Medical Reimbursement (*Maximum Annual Amount - $2,750*)
$_________________Annual Contribution

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

Health Savings Account **Pre-Tax** **(Can only change amount)** ☐ Decline

Annual Contribution: $____________

(Maximum contributions: Individual - $3, 500/Family - $7,000)

AFA Disability **Post-Tax** ☐ Decline

Elimination Period:

☐ 0 Day ☐ 14 Day ☐ 30 Day
☐ 60 Day ☐ 90 Day

Monthly Benefit Amount: $_____________
Monthly Premium: $__________________

Please have an agent contact me regarding this coverage.

Ameritas Dental **Pre-Tax** ☐ Decline

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

Superior Vision **Pre-Tax** ☐ Decline

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

Texas Life Permanent Life Insurance Post-Tax ☐ Decline

☐ Employee $______________ Smoker Y / N
☐ Spouse $______________ Smoker Y / N
☐ Child(ren) $______________Max $50,000

Please have an agent contact me regarding this coverage.

AFLAC Critical Illness **Post-Tax** ☐ Decline
Low or High Plan

☐ Employee $___________ Smoker Y / N
☐ Spouse $___________ Smoker Y / N
☐ Child(ren) $___________

Please have an agent contact me regarding this coverage.

Dearborn Term Life **Post-Tax** ☐ Decline

☐ Employee Coverage $_______________
☐ Spouse Coverage $_______________

☐ Child(ren) $10,000

Please have an agent contact me regarding this coverage.

AFLAC Accident **Pre-Tax** ☐ Decline
Option 1 Or Option 2 (Please circle)

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

Premium:
$___________________________

Please have an agent contact me regarding this coverage

AFA Cancer **Post-Tax** ☐ Decline
Basic Plan Or Enhanced Plus Plan (Please Circle)

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

Premium:
$___________________________

Please have an agent contact me regarding this coverage.

AFLAC Hospital Indemnity **Post-Tax** ☐ Decline

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

Premium:
$___________________________

Please have an agent contact me regarding this coverage

Section 5 – Beneficiary Designation (*Please Print*) **This section must be completed for group life insurance and other voluntary life insurance.**

Name	Date of Birth	Gender M/F	Relationship to Insured	Percentage
Primary				
Contingent				

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: ______/_______/________

**** Upon completion of this form return to jclark@pisd.net or cody.taff@ffga.com ****