



BENEFIT CHANGE FORM



Section 1 – Employee Information I have a qualifying Life event: Marriage New Child Divorce Loss of Coverage

Desoto ISD		Plan Year:			
Employee Name:		Social Security Number:		Date of Birth:	
Annual Salary:	Gender:	Hire Date:	Campus Location:		
Mailing Address (Street Apt):			City	State	Zip
Home Phone Number:			Email:		

Section 2 – Family Information

Dependent Name	Date of Birth	Gender	SS Number	Beneficiary (% must total 100%)	
				Primary	Contingent
Spouse					
Child					
Child					
Child					
Child					

Section 3 – Benefit Election **YOU MUST CHECK ALL WAIVED BENEFITS PLEASE**

<p>TRS BCBS Medical: <input checked="" type="checkbox"/> Pre-Tax <input type="checkbox"/> Waive</p> <p><input type="checkbox"/> ActiveCare Primary <input type="checkbox"/> ActiveCare HD</p> <p><input type="checkbox"/> ActiveCare Primary +</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse</p> <p><input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family</p> <p>Primary/Primary+ Must provide PCP Name & PHI Number:</p> <p>https://www.bcbstx.com/trsactivecare/doctors-and-hospitals</p>	<p>Flexible Savings Account (FSA) <input type="checkbox"/> Waive</p> <p><input type="checkbox"/> Individual Coverage (Maximum Annual Amount - \$3,400) \$_____ Annual Contribution</p> <p>You cannot enroll into a FSA plan if you are currently enrolled into a HSA plan.</p> <p>HSA Pre-Tax Waive Annual Contribution: \$_____ Maximum contributions: Individual - \$4,750 Family - \$8,400</p>	<p>Aetna Hospital Indemnity Plan</p> <p><input type="checkbox"/> Waive</p> <p><input type="checkbox"/> Low <input type="checkbox"/> High</p> <p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Employee/Spouse</p> <p><input type="checkbox"/> Employee/Child</p> <p><input type="checkbox"/> Employee/Family</p>
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Ameritas Vision: (Pre-tax) <input type="checkbox"/> Waive <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	Ameritas Dental: (Pre-tax) <input type="checkbox"/> Waive <input type="checkbox"/> Enhanced <input type="checkbox"/> Basic <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	Recuro Telehealth: (Pre-tax) <input type="checkbox"/> Waive <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family
The Standard Accident: (Pre-tax) <input type="checkbox"/> Waive <input type="checkbox"/> Enhanced <input type="checkbox"/> Basic <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	AFLAC Critical Illness: (Pre-tax) <input type="checkbox"/> Waive <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	The Standard Disability: (After-Tax) <input type="checkbox"/> Waive <input type="checkbox"/> High Plan <input type="checkbox"/> Low Plan Elimination Period: <input type="checkbox"/> 15 Day <input type="checkbox"/> 31 Day <input type="checkbox"/> 61 Day <input type="checkbox"/> 91 Day <input type="checkbox"/> 151 Day Monthly Benefit Amount: _____
MASA Medical Transport: <input type="checkbox"/> Waive <input type="checkbox"/> Emergent Plan <input type="checkbox"/> Platinum Plan <input type="checkbox"/> Employee <input type="checkbox"/> Family	Texas Life <input type="checkbox"/> Waive <input type="checkbox"/> Employee Coverage \$ _____ <input type="checkbox"/> Spouse Coverage \$ _____ <input type="checkbox"/> Child(ren) \$25,000 or \$50,000	AFA Life <input type="checkbox"/> Waive <input type="checkbox"/> Employee Coverage \$ _____ <input type="checkbox"/> Spouse Coverage \$ _____ <input type="checkbox"/> Child(ren) \$25,000 or \$50,000
<i>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.</i>		
Employee Signature: x _____ Date: ____/____/____		

***When you have completed this form, please return it to **Camela Reed**, crystal.reed@desotoisd.org
Please review all benefits available to Desoto ISD employees at: <https://benefits.ffga.com/desotoisd/>**