IRVING ISD 2020-2021 BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE: _____

Employee Name (Last, First, Middle)	Title/Position	Social Security Number	Employee ID#
Home Address (Street, Apt.#)	**City State Zip Home Phone Number**	**Date of Birth**	**Pay Period**
	( )		☐ Monthly ☐ Biweekly

REASON FOR REQUEST

You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Human Resources-Compensation Benefits Office within 31 days of the change. Proof of change is required. Your request will be denied if you fail to notify the Human Resources-Compensation Benefits Office within 31 days. Complete "Covered Family Members" section with the names of family members to be added or canceled.

CHECK REASON FOR CHANGE

☐ Marriage ☐ Divorce ☐ Birth/Adoption of a child/Gains legal guardianship ☐ Death of spouse or dependent ☐ Dependent becomes eligible ☐ Dependent becomes ineligible ☐Loses Coverage

☐ Loss of other qualified group coverage ☐ Spouse changes employment - Gains Coverage ☐ Spouse changes employment - Loses Coverage ☐ Other - Explain_____

(COMPLETE CHART WITH CHANGES RELATIVE TO THE QUALIFIED EVENT INFORMATION EMPLOYEE IS PROVIDING)

COVERAGE	☐ Add ☐ Remove ☐ Change	Plan Level or Amount PCP#_____
Medical - (Provide PCP# for Primary & Primary+)	☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Family	☐ Primary ☐ HD ☐ Primary +(Plus) ☐ Active Care2 ☐ S&W HMO
HSA	☐ Employee ☐ Family	Amount Per Pay Period $ Annual Max: Ind. $3,450 Fam. $6,900
FSA-Medical Reimbursement (Flexible Spending)	☐ Employee	Amount Per Pay Period $ Annual Max :$2,650
Hospital Indemnity Plan	☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Family	☐ Option 1 - $1,500 ☐ Option 2 - $2,500
Dental	☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Family	☐ DMO Facility #_____ ☐ High PPO ☐ Low PPO
Vision	☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee + Family	
Cancer	☐ Employee ☐ Employee + Child(ren) ☐ Employee + Family	☐ High Option Basic Plan ☐ Basic + ICU Rider ☐ Low Option Basic Plan ☐ Basic + ICU Rider
Disablity	☐ Employee	Waiting Period Coverage $
Group Life	☐ Employee ☐ Spouse ☐ Child(ren)	Policy EE $ K SP $ _K CH $ _K
Dependent Care Reimbursement	☐ Employee	Amount Per Pay Period $ Annual Max: Single $2,500 Family $5,000
	☐	

COVERED FAMILY MEMBERS INFORMATION

If adding or removing a qualified family member, you must complete all family member information requested. If changing coverage, only list the member(s) with the qualified change.

SPOUSE _____ DATE OF BIRTH_____ SSN_____ ☐ Male ☐ Female

CHILD _____ DATE OF BIRTH_____ SSN_____ ☐ Male ☐ Female

CHILD _____ DATE OF BIRTH_____ SSN_____ ☐ Male ☐ Female

CHILD _____ DATE OF BIRTH_____ SSN_____ ☐ Male ☐ Female

For Office Use:

[ ] Accepted [ ] Denied

Date Received:_____

Received by :_____

Important: I understand and have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand that the above selections may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I also understand that changes resulting in the addition of coverage will be effective the 1st day of the month following the qualifying event. I will be responsible for paying back any missed premiums. If dropping coverage, the effective date will be the 1st of the month following the signature date.

Signature _____ Date _____

Please email/fax completed form and supporting documentation to the Benefits Office at HR-CompAndBenefits@irvingisd.net / 972.215.5469

TRS MEDICAL INSURANCE					
12 Pay Rates- Professional & Paraprofessional					
Tier	ActiveCare Primary	ActiveCare HD	ActiveCare Primary +	ActiveCare 2	Scott & White HMO
Employee Only	$0	$11	$128	$551	$165.10
Employee + Spouse	$703	$734	$878	$1,836	$996.06
Employee + Children	$309	$329	$448	$1,007	$497.50
Employee + Family	$915	$952	$1,202	$2,241	$1,092.56
24 Pay Rates - Facilities Services & Operations					
Employee Only	$0	$5.50	$64	$275.50	$82.55
Employee + Spouse	$351.50	$367	$439	$918	$498.03
Employee + Children	$154.50	$164.50	$224	$503.50	$248.75
Employee + Family	$457.50	$476	$601	$1,120.50	$546.28
17 Pay Rates - Food Service & CAO's					
Employee Only	$0	$7.76	$90.35	$388.94	$116.54
Employee + Spouse	$496.24	$518.12	$619.76	$1,296	$703.10
Employee + Children	$218.12	$232.24	$316.24	$710.82	$351.18
Employee + Family	$645.88	$672	$848.47	$1,581.88	$771.22

TELEHEALTH

Full Family Coverage is available at no cost for full-time employees that enroll in ActiveCare Primary and ActiveCare -HD or waive medical.

VISION

$125 frame allowance or $130 contact lens allowance.
Exam/Lenses/Contacts: 12 months and Frames 12 months.

Employee Only	$7.98
Employee + Spouse	$15.76
Employee + Children	$15.44
Employee + Family	$23.50

DENTAL

High PPO
Calendar year maximum of: $1,500 per insured person.

Tier	12 Pay Rates	24 Pay Rates	17 Pay Rates
Emp Only	$34.54	$17.27	$23.02
Emp + Spouse	$59.14	$29.57	$39.42
Emp + Children	$82.30	$41.15	$54.86
Emp + Family	$115.82	$57.91	$77.21

Low MAC Plan
Calendar year maximum of: $750 per insured person.

Tier	12 Pay Rates	24 Pay Rates	17 Pay Rates
Emp Only	$24.20	$12.10	$16.13
Emp + Spouse	$41.50	$20.75	$27.66
Emp + Children	$57.74	$28.87	$38.49
Emp + Family	$81.24	$40.62	$54.16

DHMO
Participant must choose an in-network primary care dentist.

Tier	12 Pay Rates	24 Pay Rates	17 Pay Rates
Emp Only	$15.56	$7.78	$10.98
Emp + Spouse	$31.12	$15.56	$20.74
Emp + Children	$39.84	$19.92	$26.56
Emp + Family	$43.74	$21.87	$29.16