

# ARLINGTON ISD 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
							( )		____/____/____	<input type="checkbox"/> 12 Pay <input type="checkbox"/> 18 Pay <input type="checkbox"/> 26 Pay

**REASON FOR REQUEST** \* If you drop medical coverage during the plan year, you will not be able to add medical again until the following plan year even if it is due to a qualifying event.

You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Benefits Department within 31 days of the change. Proof of the change is required. Your request will be denied if you fail to notify the Benefits Office within 31 days. Complete the "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  
 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	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change	Plan Level or Amount
<b>Medical*</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 1 HD <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3
<b>Dental</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> DMO <input type="checkbox"/> HIGH PPO <input type="checkbox"/> LOW PPO
<b>Vision</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	
<b>Cancer</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Employee + Family	High Option <input type="checkbox"/> Basic Plan <input type="checkbox"/> Basic + ICU Rider Low Option <input type="checkbox"/> Basic Plan <input type="checkbox"/> Basic + ICU Rider
<b>Disability</b>	<input type="checkbox"/> Employee	Waiting Period _____ Coverage \$ _____
<b>Texas Life</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	Policy EE \$ _____ K SP \$ _____ K CH \$ _____ K Premium \$ _____ \$ _____ \$ _____
<b>Group Life</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	Policy EE \$ _____ K SP \$ _____ K CH \$ _____ K Premium \$ _____ \$ _____ \$ _____
<b>Medical Reimbursement</b>	<input type="checkbox"/> Employee	Amount Per Pay Period \$ _____ Annual Max \$3600
<b>Dependent Care Reimbursement</b>	<input type="checkbox"/> Employee	Amount Per Pay Period \$ _____ Annual Max \$5000
<b>Identity Theft Protection</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family	

**COVERED FAMILY MEMBERS INFORMATION**

If adding 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 Benefits Department Use:**

Accepted  
  Denied  
  
 Date Received \_\_\_\_\_  
  
 Approved by \_\_\_\_\_  
  
 Entered in Benefits Hub: \_\_\_\_\_

**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 are effective the 1<sup>st</sup> day of the month following the qualifying event.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please fax completed form and supporting documentation to the Benefits Office at 817-459-7162**