ARLINGTON ISD BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE_____

PERSONAL INFORMATION

Employee Last Name	First Name	SSN	Emp ID #

Address	City	State	ZIP Code

Home Phone	Date of Birth	Pay Period:	☐ 12 Pay	☐ 18 Pay	☐ 26 Pay

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 Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female
Childs Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female
Childs Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female
Childs Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female

REASON FOR REQUEST/QUALIFIED 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 change is required. Your request will be denied if you fail to notify the Benefits Office within 31 days. Complete "Covered Family Members" section with the names of family members to be added or canceled.

- ☐ 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 _____

COVERAGE

Complete chart with changes relative to the reason form request/qualified event

☐ **Add** ☐ **Remove**

WELLNESS PROGRAM: I choose to participate in the Employee Wellness Program ☐ **Yes** ☐ **No**

MEDICAL	DENTAL	VISION	MEDLINK MEDICAL GAP PLAN
☐ Plan 1-HD ☐ Plan 2 ☐ Select Plan ☐ Scott & White HMO	☐ High PPO ☐ Low PPO ☐ DHMO	☐ Vision	☐ Medlink Medical Gap Plan
LEVEL OF COVERAGE ☐ Employee ☐ Spouse ☐ Children ☐ Employee + Family	**LEVEL OF COVERAGE** ☐ Employee ☐ Spouse ☐ Children ☐ Employee + Family	**LEVEL OF COVERAGE** ☐ Employee ☐ Spouse ☐ Children ☐ Employee + Family	**LEVEL OF COVERAGE** ☐ Employee ☐ Spouse ☐ Children ☐ Employee + Family

WELLNESS PROGRAM	HEALTHCARE SAVINGS ACCOUNT	TELE-HEALTH	CANCER
	Monthly Amount:_____ $3,350 Annual Individual Maximum $6,750 Annual Maximum	☐ MDLIVE	☐ High Option Basic Plan ☐ High Option + ICU Rider ☐ Low Option Basic Plan ☐ Low Option + ICU Rider
LEVEL OF COVERAGE ☐ Employee	**LEVEL OF COVERAGE** ☐ Employee	**LEVEL OF COVERAGE** ☐ Employee ☐ Employee + Family	**LEVEL OF COVERAGE** ☐ Employee ☐ Children ☐ Employee + Family

DISABILITY **Waiting Period:**_____ **Coverage Amount:**_____	**GROUP LIFE** **Employee Coverage Amount:**_____ **Spouse Coverage Amount:**_____ **Child Coverage Amount:**_____	**MEDICAL REIMBURSEMENT** **Monthly Amount:**_____ **$2,550 Annual Maximum**
LEVEL OF COVERAGE ☐ **Employee**	**LEVEL OF COVERAGE** ☐ **Employee** ☐ **Spouse** ☐ **Child**	**LEVEL OF COVERAGE** ☐ **Employee**

DEPENDENT CARE REIMBURSEMENT **Monthly Amount:**_____ **$5,000 Annual Maximum**	**IDENTITY THEFT PROTECTION** ☐ **ID Watchdog Plus** ☐ **ID Watchdog Platinum**	**LEGAL SERVICES** ☐ **Metlaw Hyatt Legal Plan**
LEVEL OF COVERAGE ☐ **Employee**	**LEVEL OF COVERAGE** ☐ **Employee** ☐ **Spouse** ☐ **Child**	**LEVEL OF COVERAGE** ☐ **Employee** ☐ **Employee + Family**

☐ I have reviewed and understand the benefit plans and rates located on the Benefits website (www.myaisdbenefits.net). I authorize any payroll deductions required for the benefit selections I have made on this form. 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 the completed form to hrbenefits@aisd.net or fax to 682-867-4651