BENEFIT CHANGE FORM

Complete and return this form to the Benefit Dept. within 31 days of a status change

Higginbotham™ Public Sector

Employee Information

Legal First Name _____ MI _____ (i.e. Elizabeth)

Legal Last Name _____ (i.e. Smith)

EP# _____

Position _____

Date of Birth _____ (i.e. 01/01/1970)

M / F _____

Home Address _____

City _____

State _____

Zip Code _____

Preferred Phone Number _____

Pay Frequency

Circle One: Monthly or Semi-Monthly

Email Address _____

Employee Signature _____

Date Signed _____

I hereby certify that the above information is true and correct to the best of my knowledge and that evidence of the above events must be submitted to the Plan Administrator. I understand that Change in Family Status is subject to validation and approval of Administrator.

Change in Family Status

Instructions: Place your initials in the box for the status change you have experienced within the past 31 days and the date of the change:

Marriage	☐	Date _____
Divorce	☐	Date _____
Birth or Adoption	☐	Date _____
Change in Job of Spouse	☐	Date _____
Death	☐	Date _____
Other	☐	Date _____

Circle One: Adding Coverage or Dropping Coverage

Dependent To Add or Drop

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

Dependent Name _____

Date of Birth _____ M / F _____

Relationship _____

For Employee Benefits Department Use

New Coverage Effective Date _____

Payroll Effective Date _____

Pay Frequency _____

Benefit Administrator Signature _____

Date Signed _____

BENEFIT CHANGES

First Name: _____ **Last Name:** _____

Instructions: Place you initials in the box for the plan you wish to elect.

All Pre -Tax changes must correspond to a status change.

TRS Medical Coverage

Select Your Plan		Select Your Coverage Category	
TRS ActiveCare Primary *	☐	Employee Only	☐
TRS ActiveCare HD	☐	Employee + Spouse	☐
TRS ActiveCare Primary + *	☐	Employee + Child(ren)	☐
TRS ActiveCare 2 (No new enrollment allowed)	☐	Employee + Family	☐
		Split Premium (Spouse with another TRS Health District)	☐
		Pool Premium (Lewisville ISD Spouse)	☐
		Decline Medical	☐

* **PCP Code for Primary, Primary+ & HMO:** _____

METLife standard Dental Plan

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

METLife basic Dental Plan

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

Decline Dental Plans ☐

United HealthCare Vision

Employee Only	☐
Employee + Spouse	☐
Employee + Child(ren)	☐
Employee + Family	☐
Decline Vision	☐

EECU Health Savings Account

Monthly Employee Amount	Annual Limit
$ _____	$ 4,150
Monthly Family Amount	
$ _____	$ 8,300

Cancel / Decline H.S.A ☐

UNUM Voluntary Employee Life

Employee Coverage $ _____

Cancel / Decline Employee Life ☐

UNUM Voluntary Spouse Life

Spouse Coverage $ _____

Cancel / Decline Spouse Life ☐

*** Spouse coverage can only be added in the event of a Marriage if Employee is currently enrolled in Unum Voluntary Employee Coverage.**

UNUM Voluntary Child Life

**** Note– Spouse and Child amount may not exceed 50% of Employee coverage and Employee coverage is required to elect Spouse and Child life coverage.***

$2,000	☐
$4,000	☐
$6,000	☐
$8000	☐
$10,000	☐
Cancel / Decline Dependent Life	☐

*** Child coverage can only be added in the event of a Birth if Employee is currently enrolled in Unum Voluntary Employee Coverage.**

NBS Flexible Spending Accounts

Monthly Dependent Care Amount	Annual Limit
$_____	$5,000

*** Dependent Care Spending coverage can only be added in the event of a Birth.**

Decline Reimbursement Accounts ☐