EAGLE MOUNTAIN SAGINAW ISD
Payroll and Benefits

BENEFIT ELECTION/CHANGE FORM

First Financial Group of America
First in Service and Expertise

☐ New Hire Enrollment ☐ Qualifying Event ☐ Termination

Section 1 - Life Event Change (Only complete if qualifying event) Pre-Tax Insurance

You may make elections changes during the Section 125 Plan Year if you have a qualifying event and you notify the Benefits Department within 31 days of the event. Please complete all information.

Reason for request: ☐ Marriage / Divorce ☐ Death of a Spouse or Dependent ☐ Birth or Adoption of a Child ☐ Loss of Coverage
☐ Job Status Change for Employee or Spouse ☐ Termination/Commencement of Spouse's Employment

☐ Other (Please Explain):_____ **Effective Date of Change:**____/___/____

Section 2 – Employee Information (*Please Print*)

Employee Name:			Social Security Number	Date of Birth:
Gender:	Marital Status:	Phone Number:	Email address:	
Mailing Address:				
Physical Address *(required if mailing address is PO Box)*:				

For the Benefits Department use only:			
Annual Salary: $	Hire Date:	Occupation:	Location:
Hours worked:	Pay Frequency: __12 ___20 ___26	Effective Date:	Termination Date:

Section 3 – Family Information (*Please Print)*

Dependent Name	SSN	DOB	M/F	Add or Drop
Spouse				
Child				
Child				
Child				
Child				

*NOTE: IF YOU ARE ENROLLING INTO THE PRIMARY OR PRIMARY + PLAN, YOU WILL NEED TO PROVIDE THE PHI NUMBER FOR YOUR PCP. https://www.bcbstx.com/trsactivecare/doctors-and-hospitals

Section 4 – Benefit Selection (*Please indicate election by using an "X"*)

TRS Medical Pre-Tax ☐ Decline

Effective: ☐ Actively at Work Date ☐ First day of month following

☐ Activecare HD ☐ Primary Plan ☐ Primary + ☐ Baylor HMO

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

☐ Split Premium(Spouse works at other district(additional form needed)
☐ Pooled Premium (Spouse is also employed by EMS ISD)

*PRIMARY AND PRIMARY + MUST PROVIDE PCP INFO BELOW:

PCP Name: _____

PCP-PHI NUMBER_____

(STARTS WITH A LETTER "H")

Flexible Spending Accounts Pre-Tax ☐ Decline

☐ Medical Reimbursement (*Maximum Annual Amount - $2,700)*
$_____ Annual Contribution

☐ Dependent Care Reimbursement (*Maximum Annual Amount - $5,000)*
$_____ Annual Contribution

Health Savings Account Pre-Tax (Can only change amount)
☐ Decline

Annual Contribution: $_____

Maximum contributions: Individual - $3, 500/Family - $7,000

*NEW ENROLLEES MUST PROVIDE DL#_____

AFA Disability Post-Tax ☐ Decline

Elimination Period:

☐ 7 Day ☐ 14 Day ☐ 30 Day
☐ 60 Day ☐ 90 Day ☐ 180 Day

Monthly Benefit Amount: $_____
Monthly Premium: $_____

Metlife Dental Pre-Tax ☐ Decline

☐ High ☐ Low

☐ Employee Only
☐ Employee + One Dependent

Dependent Name:

_____

☐ Employee & Family

Metlife Vision Pre-Tax ☐ Decline

☐ Employee Only
☐ Employee + One Dependent

Dependent Name:

_____

☐ Employee + 2 or more dependents

TEXAS LIFE INSURANCE Post-Tax
☐ Decline

☐ Employee $_____
☐ Spouse $_____
☐ Child(ren) $25,000 or $50,000

Metlife Critical Illness Post-Tax ☐ Decline

☐ Employee $_____
☐ Spouse $_____
☐ Child(ren) $_____

UNUM Term Life Post-Tax ☐ Decline

☐ Employee Coverage $_____
☐ Spouse Coverage $_____

☐ Child(ren) $10,000

Metlife Accident Post-Tax ☐ Decline

☐ High ☐ Low

☐ Employee Only
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee & Family

TransAmerica GAP Plan Post-Tax ☐ Decline

☐ Employee
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee & Family

Aetna Hospital Indemnity Plan Post-Tax
☐ Decline

☐ Employee
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee & Family

Section 5 – Beneficiary Designation (*Please Print)*

Primary Beneficiary:

Name_____

Date of Birth_____

Relationship_____

Percentage_____

Contingent Beneficiary:

Name_____

Date of Birth_____

Relationship_____

Percentage_____

Section 6 - Signatures

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.

Employee Signature: x_____ Date: _____/_____/_____

Benefits Administrator Signature: x_____ Date: _____/_____/_____