EAGLE MOUNTAIN SAGINAW ISD
Payroll and Benefits

Eagle Mountain-Saginaw Independent School District provides health coverage to employees through TRS-ActiveCare. According to TRS ActiveCare Guidelines, an employee of the district who is reasonably expected to work at least 10 hours per week is eligible to enroll in medical coverage.

Although the District reasonably expects substitute/part-time/temporary employees to work at least 10 hours per week, the District does not guarantee that you will receive 10 hours every week. The District's need for substitute/part-time/temporary employees varies from week to week. In some weeks, you may not receive any assignments. Similarly, the District understands that some weeks you may not be able to accept assignments due to illness or other personal reasons.

If you are a substitute/part-time/temporary employee, you must enroll in or decline medical coverage within 31 days from your date of hire. If you are a returning substitute/part-time/temporary employee, you must enroll in or decline medical coverage during the annual open enrollment. If you decline coverage, you cannot enroll again until the next plan year unless you experience a qualifying event.

If you elect to enroll, **you will be responsible for the full premium.** Your first premium will be taken out of your paychecks and subsequent months thereafter and any amounts that are not paid for will be due in the Benefits Department on the scheduled payroll date. If you elect coverage to start on your actively-at-work date you may owe a back premium depending on the date that it falls on. If you fail to submit payment of your monthly premiums, the District will proceed with the coverage cancellation process.

A substitute/part-time/temporary employee who is enrolled in TRS-Active Care and who is then removed from the substitute roster becomes ineligible for health coverage and will be provided notice regarding continuation coverage under COBRA (if eligible). Cancellation due to non-payment is considered a personal request for cancellation. Therefore you would not be eligible for COBRA.

Print Name: _____

Job Title: _____

Date of Hire: _____

I hereby acknowledge receipt of information regarding Health Insurance Coverage. I understand that I am being offered insurance as a new hire. Should I transfer into a full time position, I will not be eligible to make any medical insurance changes unless there is a qualifying event such as marriage, birth of a child, loss of other coverage, etc.

If I have any additional questions, I will contact Jamie Erwin, Benefits Specialist in the Benefits Department for more information at 817-847-2978 or jmcnutt-erwin@ems-isd.net or visit https://www.emsisd.com/Page/41700

Signature: _____ **Date:** _____

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Eagle Mountain-Saginaw ISD 18-19
ENROLLMENT/DECLINATION FORM
SUBSTITUTES/PART-TIME Employees

Employee Name (Last, First, Middle) **Title/Position**	**Social Security Number**
Home Address (Street, Apt.) City State Zip Phone Number	**Date of Birth** **Pay Period** **□ Monthly □ Biweekly**
□ I choose to enroll □ I am declining coverage	**HIRE DATE: _____**

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

COVERAGE	**☐ Add ☐ Remove ☐ Change**	**Plan**
Medical	**□ Employee □ Spouse □ Child(ren) □ Employee + Family**	**□ Plan 1 HD □ Select □ Plan 2 □ HMO**

TO ENROLL OR DECLINE IN COVERAGE SUBMIT THIS FORM TO THE BENEFITS DEPARTMENT WITH PAYMENT AND THEN YOU MUST CALL THE PEC Benefits Call Center at 1-888-294-1752 TO ENROLL IN COVERAGE.

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 Specialist within 30 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: _____

Tier	TRS-ActiveCare 1- HD	TRS-ActiveCare Select- Baylor Scott & White Quality	TRS-ActiveCare 2 Not available for new	TRS-ActiveCare-HMO Scott & White Health Plan
Employee ONLY	$367	$540	$782	$578.36
Employee & Spouse	$1,035	$1,327	$1,855	$1,353.40
Employee & Child(ren)	$701	$876	$1,163	$908.06
Employee & Family	$1,374	$1,668	$2,194	$1,509.56

FOR OFFICE USE ONLY:

[ ] Accepted [ ] Denied

Date Received: _____
Received by: _____
Payment Amount Received: _____