

BENEFIT ELECTION/CHANGE FORM

☐ 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 + ☐ ☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Employee & Family *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 - \$3,050) \$_____ 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, 850/Family - \$7,750 *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	Critical Illness Post-Tax ☐ Decline ☐ Employee \$_____ ☐ Spouse \$_____ ☐ Child(ren) \$_____	UNUM Term Life Post-Tax ☐ Decline ☐ Employee Coverage \$_____ ☐ Spouse Coverage \$_____ ☐ Child(ren) \$10,000	
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	
AFA Cancer Post-Tax ☐ Decline ☐ High \$15,000 ☐ Low \$10,000 ☐ Employee Only ☐ Employee & Family	Telehealth Plan Pre-Tax Decline ☐ ☐ Employee ☐ Employee & Family	MASA Medical Transport Post-Tax ☐ Decline ☐ Emergent Plan \$14 ☐ Premier Plan \$19 ☐ Platinum Plan \$39 ☐ Employee ☐ Employee & Family	

Section 5 – Beneficiary Designation *(Please Print)*

Primary Beneficiary:	Contingent Beneficiary:
Name _____	Name _____
Date of Birth _____	Date of Birth _____
Relationship _____	Relationship _____
Percentage _____	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: ____/____/____