



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.** Payments will be deducted from your paycheck. If you do not receive a check you will be invoiced directly and any amounts that are not paid for will be due in the Benefits Department. If payment is not made by the due date we will deduct the past due amount from future pay and your benefits will thereafter be cancelled due to non-payment. 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/domain/113>

Signature: _____

Date: _____



**Eagle Mountain-Saginaw ISD 21-22
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 <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly
<input type="checkbox"/> I choose to enroll <input type="checkbox"/> I am declining coverage		HIRE DATE: _____

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

COVERAGE	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change	Plan
Medical	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Primary <input type="checkbox"/> HD <input type="checkbox"/> Primary + <input type="checkbox"/> HMO

TO ENROLL OR DECLINE IN COVERAGE SUBMIT THIS FORM TO THE BENEFITS DEPARTMENT AND THEN YOU WILL GO TO [HTTPS://FFBENEFITS.FFGA.COM/EAGLEMOUNTAINSAGINAWISD](https://ffbenefits.ffga.com/eaglemountainsaginawisd) TO ENROLL.

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 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: _____

Tier	TRS ActiveCare Primary	TRS ActiveCare HD	TRS-ActiveCare Primary +	TRS-ActiveCare 2 <small>Not available for new enrollment.</small>	TRS-ActiveCare- HMO Scott & White Health Plan
Employee ONLY	\$417	\$429	\$542	\$1,013	\$542
Employee & Spouse	\$1,176	\$1,209	\$1,334	\$2,402	\$1,363
Employee & Child(ren)	\$751	\$772	\$879	\$1,507	\$872
Employee & Family	\$1,405	\$1,445	\$1,675	\$2,841	\$1568

FOR OFFICE USE ONLY:

[] Accepted [] Denied

Date Received: _____

Received by: _____

Payment Amount Received: _____