BIRDVILLE ISD BENEFITS CHANGE FORM

Employee Name (First, Middle, Last)	Employee ID# or DOB	Date of Qualifying Event (Must be within 31 days of document submission)

➢ **CHECK REASON FOR CHANGE (QUALIFYING EVENT):**

☐ Marriage/Divorce ☐ Birth/Adoption/Legal Guardianship change of a child ☐ Death of a dependent

☐ Change in dependent eligibility ☐ Gain/loss of other coverage ☐ Other _____

➢ **PLEASE SELECT BELOW YOUR *NEW* ENROLLMENT ELECTION. Only select the benefits you are changing.**

COVERAGE	ENROLL/CHANGE COVERAGE TIER TO	ENROLL/CHANGE PLAN LEVEL OR AMOUNT TO
Medical	□ Employee □ Emp & Spouse □ Emp & Child □ Family □ Cancel All Coverage	□ AC HD □ AC Primary* □ AC Primary+ * * Requires selecting an in-network provider. Please list below.
Dental	□ Employee □ Emp & Spouse □ Emp & Child □ Family □ Cancel All Coverage	□ DHMO* □ PPO Low □ PPO High * Requires selecting an in-network provider. Please list below.
Vision	□ Employee □ Emp & Spouse □ Emp & Child □ Family □ Cancel All Coverage	
Cancer	□ Employee □ Emp & Spouse □ Emp & Child □ Family □ Cancel All Coverage	□ Level 1 □ Level 2
Critical Illness	□Employee □ Spouse □ Cancel All Coverage	EE $ SP $
Hospital Indemnity Plan	□ Employee □ Emp & Spouse □ Emp & Child □ Family □ Cancel All Coverage	□ Plan 1 ($1,500) □ Plan 2 ($2,500)
Group Term Life	□ Employee □ Spouse □ Child(ren) □ Cancel All Coverage	Emp $ Spouse $ CH $10,000
AD&D	□ Employee □ Family □ Cancel All Coverage	Amount $
ID Theft Protection	□Employee □ Family □ Cancel All Coverage	
Legal Services	□ Family □ Cancel All Coverage	
Emergency Transport	□ Family □ Cancel All Coverage	
Health Reimbursement (HSA)		Amount Per Month $
Flexible Spending Account (FSA)		Amount Per Month $
Dependent Care Reimbursement (DCA)		Amount Per Month $

EMPLOYEE/DEPENDENT NAME	Date of Birth	MEDICAL provider name and city (AC Primary and AC Primary+ Only):	DENTAL provider name and city (Dental HMO Only):

Important: I understand and have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand 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 contact within 31 days of the qualifying event. Any addition of coverage will be effective the first day of the month following the qualifying event. I will be responsible for paying back any missed premiums. Any deletion of coverage will be effective the 1st of the month following the later of the qualifying event or document submission date.

Signature: _____ Date: _____

Fax to the Benefits Office @ 817-547-5580 or email to susan.dippolito@birdvilleschools.net. If you are adding a dependent, please log into THE*benefits*HUB and add the dependent's demographic information. A social security number is required unless the dependent is a new born.

- **QUALIFYING EVENT SUPPORT DOCUMENTATION REQUIREMENTS:**
  - Marriage – submit a copy of the marriage certificate.
  - Divorce – submit a copy of the Dissolution of Marriage.
  - Birth of Child – submit documentation of birth from the hospital, such as a Proof of Vital Facts. When received, please enter the dependent's social security number via THE*benefits*HUB.
  - Adoption/Legal Guardianship – submit certified court paperwork.
  - Loss of other coverage or change – provide proof of loss of coverage such as a COBRA letter or notice from the employer.
  - Gain other coverage (other group coverage or Marketplace coverage) – provide proof of other coverage such as a copy of the new card or enrollment confirmation.