

ALLEN ISD BENEFITS CHANGE FORM

You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Benefits Department within 30 days of the change. Verifiable documentation of the qualifying event must be provided in order for the request to be processed. Your request will be denied if you fail to notify the Benefits Office within 30 days. Change in election must be related to the reason for the change. Complete "Covered Family Members" section with the names of family members to be added or canceled.

Employee Name (Last, First, Middle)		Employee ID Number	Social Security Number (if Employee ID is unknown)
Phone Number	Email Address		Qualified Life Event Date
Note: This form must be received by AISD Benefits Office within 30 days of the event.			
Enroll/Add/Change <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Other AISD Qualified Event Spouse's name (if employed by AISD):		<input type="checkbox"/> COBRA Qualifying Events <input type="checkbox"/> Divorce <input type="checkbox"/> Involuntarily Lost Coverage <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Judgment, Decree or Order <input type="checkbox"/> Other:	Delete/Cancel <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Dependent newly eligible for own benefits due to job commencement, job change or their employer's open enrollment. <input type="checkbox"/> Medicare, Medicaid or CHIP eligibility <input type="checkbox"/> Cancel coverage for me and my dependents. Reason:

Complete chart with changes relative to the qualified event information employee is providing.

Medical <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> SWHP <input type="checkbox"/> Preferred Basic <input type="checkbox"/> ActiveCare HD <input type="checkbox"/> Preferred Enhanced <input type="checkbox"/> ActiveCare Primary <input type="checkbox"/> ActiveCare Primary+	Dental <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Ameritas Hybrid <input type="checkbox"/> Ameritas Low <input type="checkbox"/> Ameritas High	Vision <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family	Medical Supplement/GAP <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> AF \$1000 <input type="checkbox"/> AF \$3000 <input type="checkbox"/> AF \$5000	Flexible Spending Account <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop Medical FSA \$ _____ /pay period (Annual Max \$2,750) Dependent Care Account \$ _____ /pay period (Annual Max \$5,000)
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Covered Family Members Information Adding a qualified family member, you must complete all family member information requested. If changing or dropping coverage, only list the member(s) with the qualified change.

Employee Info	DOB	SSN	Gender	PCP Name (Primary & Primary+ plans)	PCP ID
Spouse Name	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child Name	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child Name	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child Name	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child Name	DOB	SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female		

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 Department 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.

Employee Signature _____ Date _____

For Benefits Dept use:	<input type="checkbox"/> Accepted <input type="checkbox"/> Denied	Date Received:	Date Entered:	Date Effective:
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