ARLINGTON ISD BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE_____

PERSONAL INFORMATION

Employee Last Name	First Name	SSN	Emp ID #

Address	City	State	ZIP Code

Home Phone	Date of Birth	Pay Period:	☐ 12 Pay	☐ 18 Pay	☐ 26 Pay

COVERED FAMILY MEMBERS INFORMATION

If adding a qualified family member, you must complete all family member information requested. If changing coverage, only list the member(s) with the qualified change.

Spouse Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female
Childs Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female
Childs Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female
Childs Last Name	First Name	Date Of Birth	SSN	☐ Male ☐ Female

REASON FOR REQUEST/QUALIFIED EVENT

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 31 days of the change. Proof of change is required. Your request will be denied if you fail to notify the Benefits Office within 31 days. Complete "Covered Family Members" section with the names of family members to be added or canceled.

- ☐ Marriage
- ☐ Divorce
- ☐ Birth/Adoption of a child/Gains legal guardianship
- ☐ Death of spouse or dependent
- ☐ Loss of other qualified group coverage
- ☐ Gain of other coverage
- ☐ Other –Explain _____

COVERAGE

Complete chart with changes relative to the reason for request/qualified event

☐ **Add** ☐ **Remove**

WELLNESS PROGRAM: I choose to participate in the Employee Wellness Program ☐ **Yes** ☐ **No**

MEDICAL
- ☐ Plan 1-HD
- ☐ Plan 2 (Can only be elected if previously enrolled prior to 9/1/2018)
- ☐ Select Plan
- ☐ Scott & White HMO

LEVEL OF COVERAGE
- ☐ Employee
- ☐ Spouse
- ☐ Children
- ☐ Employee + Family

DENTAL
- ☐ High PPO
- ☐ Low PPO
- ☐ DHMO

LEVEL OF COVERAGE
- ☐ Employee
- ☐ Spouse
- ☐ Children
- ☐ Employee + Family

VISION
- ☐ Vision

LEVEL OF COVERAGE
- ☐ Employee
- ☐ Spouse
- ☐ Children
- ☐ Employee + Family

METLIFE HOSPITAL INDEMNITY PLAN
- ☐ Hospital Indemnity Plan

LEVEL OF COVERAGE
- ☐ Employee
- ☐ Spouse
- ☐ Children
- ☐ Employee + Family

HEALTHCARE SAVINGS ACCOUNT

Monthly Amount:_____
$3,500 Annual Individual
Maximum $7,000 Annual Maximum

LEVEL OF COVERAGE
- ☐ Employee

TELE-HEALTH
- ☐ MDLIVE

LEVEL OF COVERAGE
- ☐ Employee
- ☐ Employee + Family

CANCER
- ☐ High Option Basic Plan
- ☐ High Option + ICU Rider
- ☐ Low Option Basic Plan
- ☐ Low Option + ICU Rider

LEVEL OF COVERAGE
- ☐ Employee
- ☐ Children
- ☐ Employee + Family

DISABILITY	GROUP LIFE	MEDICAL REIMBURSEMENT
Waiting Period:_____ **Coverage Amount:**_____ **LEVEL OF COVERAGE** □ **Employee**	**Employee Coverage Amount:** _____ **Spouse Coverage Amount:**_____ **Child Coverage Amount:**_____ **LEVEL OF COVERAGE** □ **Employee** □ **Spouse** □ **Child**	**Monthly Amount:**_____ **$2,700 Annual Maximum** **LEVEL OF COVERAGE** □ **Employee**

DEPENDENT CARE REIMBURSEMENT	IDENTITY THEFT PROTECTION	LEGAL SERVICES
Monthly Amount:_____ **$5,000 Annual Maximum** **LEVEL OF COVERAGE** □ **Employee**	□ **ID Watchdog Plus** □ **ID Watchdog Platinum** **LEVEL OF COVERAGE** □ **Employee** □ **Spouse** □ **Child**	□ **Metlaw Hyatt Legal Plan** **LEVEL OF COVERAGE** □ **Employee** □ **Employee + Family**

☐ I have reviewed and understand the benefit plans and rates located on the Benefits website (www.myaisdbenefits.net). I authorize any payroll deductions required for the benefit selections I have made on this form. 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 Contact 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_____

Please email the completed form to hrbenefits@aisd.net or fax to 682-867-4651

TRS Medical Rates

2019-2020 TRS ActiveCare Health Insurance Premiums Without Wellness Program Incentive

12 Pay—Administrators and Professionals				
	TRS ActiveCare 1-HD	**TRS ActiveCare 2**	**TRS ActiveCare Select**	**Scott & White HMO**
Employee Only	$143.00	$617.00	$321.00	$323.54
Employee + Children	$487.00	$1,032.00	$667.00	$641.76
Employee + Spouse	$831.00	$1,785.00	$1,132.00	$1,071.58
Family	$1,180.00	$2,154.00	$1,483.00	$1,222.28

12 Pay—Para-Professionals				
	TRS ActiveCare 1-HD	**TRS ActiveCare 2**	**TRS ActiveCare Select**	**Scott & White HMO**
Employee Only	$128.00	$602.00	$306.00	$308.54
Employee + Children	$472.00	$1,017.00	$652.00	$626.76
Employee + Spouse	$816.00	$1,770.00	$1,117.00	$1,056.58
Family	$1,165.00	$2,139.00	$1,468.00	$1,207.28

18 Pay				
	TRS ActiveCare 1-HD	**TRS ActiveCare 2**	**TRS ActiveCare Select**	**Scott & White HMO**
Employee Only	$85.33	$401.33	$204.00	$205.69
Employee + Children	$314.67	$678.00	$434.67	$417.84
Employee + Spouse	$544.00	$1,180.00	$744.67	$704.39
Family	$776.67	$1,426.00	$978.67	$804.85

26 Pay				
	TRS ActiveCare 1-HD	**TRS ActiveCare 2**	**TRS ActiveCare Select**	**Scott & White HMO**
Employee Only	$59.08	$277.85	$141.23	$142.40
Employee + Children	$217.85	$469.38	$300.92	$289.27
Employee + Spouse	$376.62	$816.92	$515.54	$487.65
Family	$537.69	$987.23	$677.54	$557.21

AISD contributes the following each month to employees participating in a medical plan:

- **$235 per month for Professional employees**
- **$250 per month for all Para-Professional and Auxiliary employees**
- **The rates shown reflect the amount employees will pay if this district contribution amount is approved for the 2019-2020 plan year.**