HIGHLAND PARK ISD 2018-2019 BENEFITS CHANGE FORM

EFFECTIVE DATE OF CHANGE: _____

Employee Name (Last, First, Middle)	**Title/Position**	**Social Security Number**	**Employee ID#**
Home Address (Street, Apt.#)	**City State Zip Home Phone Number** ( )	**Date of Birth**	**Pay Period** ☐ **Monthly** ☐ **Biweekly** ☐ **Cafeteria**

REASON FOR REQUEST

You may add or cancel coverage during the Plan Year if you have a change in family status and you notify the Human Resources-Compensation Benefits Office within 31 days of the change. Proof of change is required. Your request will be denied if you fail to notify the Human Resources-Compensation Benefits Office within 31 days. Complete "Covered Family Members" section with the names of family members to be added or canceled.

CHECK REASON FOR CHANGE

☐ Marriage ☐ Divorce ☐ Birth/Adoption of a child/Gains legal guardianship ☐ Death of spouse or dependent ☐ Dependent becomes eligible ☐ Dependent becomes ineligible ☐Loses Coverage

☐ Loss of other qualified group coverage ☐ Spouse changes employment - Gains Coverage ☐ Spouse changes employment - Loses Coverage ☐ Other - Explain_____

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

COVERAGE	☐ Add ☐ Remove ☐ Change	Plan Level or Amount
Medical - TRS ActiveCare (Aetna, Scott & White)	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	☐ **AC 1 HD** ☐ **A C Select** ☐ **AC 2** ☐ **S&W HMO**
HSA - UMBank	☐ **Employee** ☐ **Family**	**Amount Per Pay Period $** **Annual Max: Ind. $3,450 Fam. $6,900**
Medical Reimbursement (Flexible Spending FSA)	☐ **Employee**	**Amount Per Pay Period $** **Annual Max : $2,650**
Dental - MetLife PDP+Network	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	
Vision – Superior Select Southwest	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	
Dependent Care Reimbursement FSA	☐ **Employee**	**Amount Per Pay Period $** **Annual Max: Single $2,500 Family $5,000**
Critical Illness - Allstate	☐ **Employee** ☐ **Employee + Child(ren)** ☐ **Employee + Family**	☐ **High Option Basic Plan $20,000** ☐ **Low Option Basic Plan $10,000**
Disability - MetLife	☐ **Employee**	**Waiting Period:** ☐ **7 day** ☐ **14 day** ☐ **30 day** ☐ **90 day**
Group Life (Additional) – Dearborn National	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)**	☐ **Employee K$**_____ ☐ **Spouse ½ K$** _____ ☐ **Child policy $10,000**
	☐ **Employee**	
Accident – American Fidelity	☐ **Employee** ☐ **Spouse** ☐ **Child(ren)** ☐ **Employee + Family**	

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 _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

CHILD _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

CHILD _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

CHILD _____ DATE OF BIRTH_____ SSN_____ ☐ **Male** ☐ **Female**

For Office Use:

[ ] Accepted [ ] Denied

Date Received:

Received by :_____

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 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 send completed form and supporting documentation to the Benefits Office by email: weaverl@hpisd.org or fax: 214-780-3014

2018 -19 TRS MEDICAL INSURANCE RATES

TIER	ActiveCare 1 –HD	ActiveCare Select	ActiveCare 2	Scott & White HMO
Employee Only	$12	$185	$427	$223.36
Employee + Spouse	$680	$972	$1,500	$998.40
Employee + Children	$346	$521	$808	$553.06
Employee + Family	$1,019	$1,313	$1,839	$1,154.56

All changes take effect the 1st of the following month (except Newborns are covered at DOB).

SUPERIOR VISION

$10 Co-Pay for Exam $10 Co-Pay for Materials
$100 Frame allowance and $125 contact lens allowance.
Exam/Lenses/Contacts: 12 months and Frames 12 months.

Employee Only	$8.16
Employee + Spouse	$13.89
Employee + Children	$14.71
Employee + Family	$22.07

MetLife Dental

Highland Park ISD PPO Group # 5441947 PDP+Network

Tier	12 Pay Rates	24 Pay Rates	19 Pay Rates
Employee Only	$0.00	$0.00	$0.00
Employee + 1	$43.67	$20.16	$27.59
Employee + Family	$93.87	$43.33	$59.29