

ESC REGION XI - ARGYLE ISD

New Hire Enrollment Qualifying Event Termination COBRA Elections

1 Employee Information

Employee Name: _____ Gender: _____ Date of Birth: (m/d/yr) _____ Social Security Number: _____
 Male / Female / / - -

Home Address: (Street, Apt #) _____ City: _____ State: _____ Zip: _____ Home Phone # : _____ Email Address: _____
 - -

2 Payroll Information

Annual Salary: _____ Pay Frequency: (9,10,12,24 etc.) _____ Date Of Hire: _____ Benefit Effective Date: _____
 / / / /

3 Qualifying Event Change

You may add or cancel coverage during the Section 125 Plan Year if you have a qualifying event and you notify the Benefits Department within 31 days of the change. Documentation, proof, and Administrator's signature are required with this form. Please complete all information.

Reason for Request: Marriage or Divorce Death of Spouse or Dependent Birth or Adoption of a Child Job Status Change for Employee or Spouse
 Termination / Commencement of Employment Self Termination / Commencement of Employment Spouse Significant Change in Health Coverage of Employee or Spouse
 Other Please Explain: _____ **Effective Date of Change:** / /

4 Termination Request

Termination Date: / / Benefit Termination Date: / / Reason for Request: _____ **I will Participate in the Section 125 Cafeteria Plan:**
 Yes No (Pre-Tax Benefits)

5 Covered Family Information

If adding/changing coverage for spouse or children, you must complete all information requested. Use another copy of this form for additional children and/or beneficiaries.

SPOUSE: _____ Date of Birth: / / SSN: - - Male Female Primary Beneficiary: _____
 CHILD: _____ Date of Birth: / / SSN: - - Male Female Relationship: _____
 CHILD: _____ Date of Birth: / / SSN: - - Male Female Contingent Beneficiary: _____
 CHILD: _____ Date of Birth: / / SSN: - - Male Female

6 Benefit Election/Changes

TRS MEDICAL: Pre-Tax Post-Tax ****Requires Application****
 TRS Plan 1 TRS Plan 2 TRS Plan 3 Waive All TRS Medical
 Employee Only Employee + Spouse Employee + Child(ren) Employee + Family

ID THEFT PROTECTION:
 Post-Tax Only
 Employee Only \$7.95
 Employee + Family \$14.95

BASIC LIFE: Post-Tax Only
 Employee Only Coverage: _____

Relationship: _____

ORAQUEST PPO DENTAL: Pre-Tax

	Low	High
Employee Only	<input type="checkbox"/> \$23.55	<input type="checkbox"/> \$29.77
Employee + Spouse	<input type="checkbox"/> \$47.12	<input type="checkbox"/> \$62.03
Employee + Child(ren)	<input type="checkbox"/> \$49.47	<input type="checkbox"/> \$69.22
Employee + Family	<input type="checkbox"/> \$75.73	<input type="checkbox"/> \$106.08

 Waive All PPO Dental

GUARDIAN DMHO DENTAL:
 Pre-Tax *Requires Dentist Code*
 Employee Only \$11.36
 Employee + Spouse \$17.97
 Employee + Child(ren) \$24.64
 Employee + Family \$29.26
 Waive All DMHO Dental

BLOCK VISION: Pre-Tax
 Employee Only \$8.60
 Employee + Spouse \$14.65
 Employee + Child(ren) \$15.50
 Employee + Family \$23.25
 Waive All Vision

UNUM DISABILITY: Post-Tax Only
Short Term Disability
Elimination Period:
 Benefit Amount: \$ _____
 \$ _____
 Waive All Disability

ACCIDENT:
 Employee Only \$12.70
 Employee + Spouse \$19.50
 Employee + Child(ren) \$20.40
 Employee + Family \$27.20
 Waive All Accident

CANCER: Waive All Cancer

	Low	Low - ICU	High	High - ICU
Individual	<input type="checkbox"/> \$16.30	<input type="checkbox"/> \$19.60	<input type="checkbox"/> \$32.40	<input type="checkbox"/> \$35.70
Family	<input type="checkbox"/> \$29.00	<input type="checkbox"/> \$35.90	<input type="checkbox"/> \$56.60	<input type="checkbox"/> \$63.50
Single Parent Family	<input type="checkbox"/> \$22.80	<input type="checkbox"/> \$27.30	<input type="checkbox"/> \$44.60	<input type="checkbox"/> \$49.10

FT DEARBORN VOLUNTARY Waive All Voluntary Life
LIFE: Post-Tax Only
 Employee Coverage: \$ _____
 Monthly Premium: \$ _____
 Spouse Coverage: \$ _____
 Monthly Premium: \$ _____
 Child(ren) Coverage \$5,000
 Child(ren) Coverage \$10,000

FT DEARBORN AD&D: Post-Tax Only
 Monthly Premium: \$ _____
 Waive All AD&D

NBS REIMBURSEMENT ACCOUNTS: Pre-Tax
 Medical Annually: \$ _____
 Dependent Care Annually: \$ _____
 NBS Flex Card is optional—check to elect.

I understand that I have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand that any qualifying event change will not be made without proper documentation.

Employee Signature X _____ Date: / / Administrator Signature X _____ Date: / /