Family Status Change Form
Plan Year 2020-2021

Employee Information

Last Name	First Name	MI	HEB ID#
Email Address		Contact #	

Reason for Change in Status

☐ Birth ☐ Adoption/Legal Custody of Child ☐ Dependent Child Over-Age ☐ Loss of Coverage

☐ Marriage ☐Divorce ☐ Death ☐ Medicare Eligible ☐ Other: ____________________________________

Section 1 – Dependent Information

LAST, FIRST NAME	DOB	SSN	GENDER		DISABLED CHILD?	
Spouse			☐ F	☐ M	☐ Yes	☐ No
Child			☐ F	☐ M	☐ Yes	☐ No
Child			☐ F	☐ M	☐ Yes	☐ No
Child			☐ F	☐ M	☐ Yes	☐ No
Child			☐ F	☐ M	☐ Yes	☐ No

Section 2 – Select Your Changes

FIRST NAME ONLY	MEDICAL		DENTAL		VISION		HOSPITAL INDEMNITY		CRITICAL ILLNESS		LIFE INSURANCE	
	ADD	DROP	ADD	DROP	ADD	DROP	ADD	DROP	ADD	DROP	ADD	DROP
Employee	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spouse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Life Insurance

Employee	☐ Add $ (Amount of Coverage) @ $__________________ per month
Spouse	☐ Add $ (Amount of Coverage) @ $__________________ per month
Child	☐ Add $10,000 per child @ $1.20 per month

Health Savings Account (only if enrolled for ActiveCare 1-HD medical plan)

Maximum Contributions: Individual $295.83 per month / Family $591.67 per month

☐ Drop ☐ Add $______________(per month) ☐ Change From: ____________ to ____________ (per month)

Flexible Spending Account & Dependent Day Care		
Maximum Contributions: FSA $225.00 per month / Day Care $416.66 per month		
FSA	☐ Add $____________(per month)	☐ Change From: ___________ to ___________ (per month)
DAY CARE	☐ Add $____________(per month)	☐ Change From: ___________ to ___________ (per month)

ActiveCare Primary (New Plan – PCP Required)		ActiveCare HD (PPO)		ActiveCare Primary+ (PCP Required)		Scott & White HMO	
Employee	☐	Employee	☐	Employee	☐	Employee	☐
Emp+Spouse	☐	Emp+Spouse	☐	Emp+Spouse	☐	Emp+Spouse	☐
Emp+Child(ren)	☐	Emp+Child(ren)	☐	Emp+Child(ren)	☐	Emp+Child(ren)	☐
Family	☐	Family	☐	Family	☐	Family	☐
PCP ID#:		NO PCP REQUIRED		**PCP ID#:**		NO PCP REQUIRED	

ActiveCare 2 (not eligible for new enrollees)			
Employee Only ☐	Emp+Spouse ☐	Emp+Child(ren) ☐	Family ☐

Dental HMO (Requires Primary Dentist)		PPO – HIGH Plan		PPO – LOW Plan	
Employee	☐	Employee	☐	Employee	☐
Employee + 1	☐	Employee + 1	☐	Employee + 1	☐
Family	☐	Family	☐	Family	☐
Dentist Code:		NO PRIMARY DENTIST REQUIRED		NO PRIMARY DENTIST REQUIRED	

Hospital Indemnity Plan			
$100 Daily Benefit/$2000 Initial Confinement Benefit		$200 Daily Benefit/$2000 Initial Confinement Benefit	
Employee	☐	Employee	☐
Employee + Spouse	☐	Employee + Spouse	☐
Employee + Chid(ren)	☐	Employee + Chid(ren)	☐
Employee + Family	☐	Employee + Family	☐

Vision Plan		
Employee Only ☐	Employee + 1 ☐	Family ☐

I understand that if I voluntarily drop coverage in the middle of the plan year for myself, my dependents and/or spouse I will NOT be able to re-enroll until another qualifying event occurs. I understand I will need to provide supporting documentation necessary to prove my status change to the benefits office within 30 days of the qualifying event date.

Initials ___________________

I understand that I am automatically enrolled to participate in Section 125 for all benefits. I understand that if I elected to participate in the flexible spending plan any funds that have not been used by the end of the Plan Document Year CANNOT be returned to me. I must "use it or lose it." I understand that I cannot change any before tax benefits until the next anniversary date except for a Change in Family Status. I further understand that my before tax elections shall remain in effect from year to year until I cancel it. I understand that I may cancel my election participation only during the annual enrollment period unless I cancel my participation due to a change in family status.

Employee Signature: ________________________________ Date: ______________________________