Family Status Change Form 2021-2022 Plan Year

Effective Date: ____________________

HEB HURST - EULESS - BEDFORD Independent School District

Employee Information

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

Reason for Change in Status

☐ Birth ☐ Marriage ☐ Divorce ☐ Death ☐ Adoption/Legal Custody of Child ☐ Over Aged Child (26) ☐ Addition/Loss of Coverage ☐ Medicare Eligible

Dependent Information – Complete if ADDING coverage

	Last Name	First Name	Date of Birth	SSN	Gender	Disabled Child?
Spouse	Last Name	First Name			☐ M ☐ F	
Child	Last Name	First Name			☐ M ☐ F	☐ Yes ☐ No
Child	Last Name	First Name			☐ M ☐ F	☐ Yes ☐ No
Child	Last Name	First Name			☐ M ☐ F	☐ Yes ☐ No
Child	Last Name	First Name			☐ M ☐ F	☐ Yes ☐ No

Select Your Changes

Select Your Changes	Medical	Dental	Vision	Hospital Indemnity	Critical Illness	Voluntary Life Ins.
Employee	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Spouse	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Child's First Name	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Child's First Name	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
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Health Savings Account

(only if enrolled for AC HD medical plan) Max contribution: Ind $300 mo. / Fam $600 mo.

☐ Drop ☐ Add $ ________________ per month

☐ Change from $_____________ TO $_______________ per month

Flexible Spending Account & Dependent Day Care

Max contribution: FSA $225.00 mo. / Day Care $416.66 mo.

*FSA ☐ Add $____________ ☐ Change to $ ___________ per mo.

DAY CARE ☐ Drop ☐ Add $ ________________ per month

*You cannot drop if you have withdrawn more than your annual contribution.

Voluntary Life Insurance

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

Medical Plans

ActiveCare Primary (PCP Required)		ActiveCare HD		ActiveCare Primary + (PCP Required)		Scott & White HMO		ActiveCare 2 *(not eligible for new enrollees)*	
Employee	☐ $192.00	Employee	☐ $204.00	Employee	☐ $317.00	Employee	☐ $317.48	Employee	☐ $788.00
Emp+Spouse	☐ $951.00	Emp+Spouse	☐ $984.00	Emp+Spouse	☐ $1,109.00	Emp+Spouse	☐ $1,137.70	Emp+Spouse	☐ $2,177.00
Emp+Child(ren)	☐ $526.00	Emp+Child(ren)	☐ $547.00	Emp+Child(ren)	☐ $654.00	Emp+Child(ren)	☐ $647.16	Emp+Child(ren)	☐ $1,282.00
Family	☐ $1,180.00	Family	☐ $1,220.00	Family	☐ $1,450.00	Family	☐ $1,343.42	Family	☐ $2,616.00
PCP ID#:		No PCP Required		PCP ID#:		No PCP Required		*You cannot re-enroll once dropped	

Dental Plans

Dental HMO *(Requires Primary Dentist)*		PPO – HIGH Plan		PPO – LOW Plan	
Employee	☐ $14.19	Employee	☐ $43.33	Employee	☐ $28.29
Employee+1	☐ $26.96	Employee+1	☐ $86.08	Employee+1	☐ $58.28
Family	☐ $42.56	Family	☐ $130.56	Family	☐ $78.65
Dentist Code:		No Primary Dentist Required		No Primary Dentist Required	

Hospital Indemnity

$100 Daily Benefit		$200 Daily Benefit	
Employee	☐ $16.19	Employee	☐ $32.38
Emp+Spouse	☐ $32.47	Emp+Spouse	☐ $64.95
Emp+Children	☐ $24.18	Emp+Children	☐ $48.36
Family	☐ $40.46	Family	☐ $80.93

Superior Vision

Employee	☐ $7.18
Employee+1	☐ $13.94
Family	☐ $20.47

Critical Illness Plan (children are automatically covered under employee)

	$10,000 Benefit	$20,000 Benefit	$30,000 Benefit
Employee			
Spouse			

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 the 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 them. 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: _____

Clear Form