BENEFITS CHANGE FORM

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 30 days of the change. Verifiable documentation of the qualifying event must be provided in order for the request to be processed. Your request will be denied if you fail to notify the Benefits Office within 30 days. Change in election must be related to the reason for the change. Complete "Covered Family Members" section with the names of family members to be added or canceled.

Employee Name (Last, First, Middle)		Employee ID #	Social Security #
Phone Number	Home Address City State Zip	Qualified Life Event Date	** This form must be received by MISD Benefits Office within 30 days of the event

***Enroll/Add**

☐ Birth/Adoption
☐ Marriage/Civil Union
☐ Divorce
☐ Involuntary Loss of Coverage
☐ Legal Guardianship
☐ Other: ________________

***Cancel/Drop**

☐ Death of Dependent
☐ Dependent/Spouse newly eligible for benefits due to job change or their employer's open enrollment
☐ Medicare, Medicaid or CHIP eligibility
☐ Cancel coverage for me and my dependents
Reason:___________________________

COMPLETE CHART WITH CHANGES RELATIVE TO THE QUALIFIED EVENT INFORMATION PROVIDED

Medical	Vision	Dental	Voluntary Life or AD&D	Flex Spending Acct	Health Savings Acct
☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family	☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family	☐ Employee ☐ Employ. +1 ☐ +2 or more Dependents	☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family	Medical $___________/pay period (Annual Max $2,750)	Medical $________/pay period
☐ ActiveCare HD ☐ ActiveCare Primary ☐ ActiveCare Primary+ ☐ SWHP	☐ Vision High Plan ☐ Vision Low Plan	(This plan is based on the # of Dependents covered. Please select based on yourself, spouse, and/or children whom you want coverage)	☐ Voluntary Life ☐ AD&D	Dependent Care Account $___________/pay period	(Annual Max) $3,600 - single $7,2500 - family

Covered Family Members information - When adding a qualifying family member, you must complete family member information. If changing/dropping coverage, only list the member(s) for qualified change.

Employee Info				PCP Name (Primary & Primary+ plans)	PCP ID
Spouse Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		
Child Name	DOB	SSN	☐ Male ☐ Female		

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 Department within 30 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.

Employee Signature ______________________________ Date ______________

For Benefits Dept. Use:

☐ *Accepted* ☐ *Denied*

Recieved By: : ________

Please send completed form and supporting documentation to awallace@mckinneyisd.net

2021-2022 TRS-ActiveCare Plans
Employee Premium

The 21-22 MISD Monthly Contribution is $306 per month for active members in TRS.

Medical Plan	21-22 Active Employee Monthly Premium	21-22 Active Employee "Per Paycheck" Premium	21-22 Sub/Temp Employee Monthly Premium
TRS-Activecare Primary			
Employee Only	$111.00	$55.50	$417.00
Employee/Spouse	$870.00	$435.50	$1,176.00
Employee/Child(ren)	$445.00	$222.50	$751.00
Employee/Family	$1099.00	$549.50	$1,405.00
TRS-Activecare HD			
Employee Only	$123.00	$61.50	$429.00
Employee/Spouse	$903.00	$451.50	$1,209.00
Employee/Child(ren)	$466.00	$233.00	$772.00
Employee/Family	$1,139.00	$569.50	$1,445.00
TRS-Activecare Primary +			
Employee Only	$236.00	$118.00	$542.00
Employee/Spouse	$1,028.00	$514.00	$1,334.00
Employee/Child(ren)	$573.00	$286.50	$879.00
Employee/Family	$1,369.00	$684.50	$1,675.00
Scott and White Plan (HMO)			
Employee Only	$236.48	$118.24	$542.48
Employee/Spouse	$1,056.70	$528.35	$1,362.70
Employee/Child(ren)	$566.16	$283.08	$872.16
Employee/Family	$1,262.42	$631.21	$1,568.42

Dental

McKinney ISD 09/01/2020 Monthly Rates		
Contract Type	Non-Retention (Non-Participating)	
Contract Term	09/01/2020 to 08/31/2022	
Guaranteed		
Rate Effective Dates	From	09/01/2020
	To	08/31/2022
Enrollee only		$44.44
Enrollee + 1 Dependent		$78.64
Enrollee + 2 or more Dependents		$101.44

Vision– Low Plan

Monthly Rates	
Employee Only	$8.90
Employee + Spouse	$15.80
Employee + Children	$18.34
Employee + Family	$23.26

Vision– High Plan

Monthly Rates	
Employee Only	$5.90
Employee + Spouse	$10.30
Employee + Children	$12.14
Employee + Family	$15.05