BENEFITS CHANGE FORM

McKINNEY INDEPENDENT SCHOOL DISTRICT

You may add or cancel coverage IF you have a Qualifying Life Event and 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.

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 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
☐ Add ☐ Drop
☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family
☐ ActiveCareHD
☐ * ActiveCarePrimary
☐ * ActiveCarePrimary+
☐ SWHP

Vision
☐ Add ☐ Drop
☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family
☐ Vision High Plan
☐ Vision Low Plan

Dental
☐ Add ☐ Drop
☐ Employee ☐ Employ. +1
☐ +2 or more Dependents
(This plan is based on the # of Dependents covered. Please select based on yourself, spouse, and/or children whom you want coverage)

Voluntary Life or AD&D
☐ Add ☐ Drop
☐ Employee ☐ Spouse
☐ Child(ren) ☐ Family
☐ Voluntary Life
☐ AD&D

Flex Spending Acct
☐ Add ☐ Drop
Medical (Annual Max: $3,050)
$_____/pay period
Dependent Care Account
(Annual Max: $2,500/$5,000)
$_____/pay period

Health Savings Acct
☐ Add ☐ Drop
Medical
$_____/pay period
(Annual Max)
$3,850 - single
$7,750 - family

** **ActiveCare Primary & Primary+ plans require a PCP on file. If adding, you *must have* the Provider's (PCP) ID# for each family member below. *Your doctors office will not have this information.*** **Please use this link to locate the PCP ID# required. https://www.bcbstx.com/trsactivecare/doctors-and-hospitals** **

COVERED FAMILY MEMBERS INFORMATION: (Complete for whom adding/canceling)

	DOB	SSN	EMPLOYEE: ☐ M ☐ F	** PCP Name (Adding Primary/Primary+ Plans)	** PCP ID#
Spouse Name	DOB	SSN	☐ M ☐ F		
Child Name	DOB	SSN	☐ M ☐ F		
Child Name	DOB	SSN	☐ M ☐ F		
Child Name	DOB	SSN	☐ M ☐ F		
Child Name	DOB	SSN	☐ M ☐ F		

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 _____

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

For Benefits Dept. Use:
☐ *Accepted* ☐ *Denied*
Recieved By: : _____

9/01/2023

2023 - 2024

MEDICAL	Active Employee Monthly Premium	Active Employee "Per-paycheck" Premium
TRS - ActiveCare Primary		
Employee	$144.00	$72.00
Employee + Spouse	$909.00	$454.50
Employee + Child(ren)	$459.00	$229.50
Employee + Family	$1,224.00	$612.00
TRS - ActiveCare Primary+		
Employee	$223.00	$111.50
Employee + Spouse	$1,070.00	$535.00
Employee + Child(ren)	$594.00	$298.50
Employee + Family	$1,440.00	$720.00
TRS - ActiveCare HD		
Employee	$156.00	$78.00
Employee + Spouse	$942.00	$471.00
Employee + Child(ren)	$480.00	$240.00
Employee + Family	$1,265.00	$632.50
Central & North Texas SWHP		
Employee	$263.76	$131.88
Employee + Spouse	$1,126.42	$563.21
Employee + Child(ren)	$610.49	$305.25
Employee + Family	$1,342.78	$671.39

***Above rates include MISD monthly employer contribution**

DENTAL (monthly rates)

Enrollee only	$45.77
Enrollee + 1 Dependent	$81.00
Enrollee + 2 or more Dependents	$104.48

VISION (monthly rates)	High Plan	Low Plan
Employee Only	$11.13	$7.38
Employee + Spouse	$19.75	$12.88
Employee + Children	$22.93	$15.18
Employee + Family	$29.08	$18.82

Learn more about MISD benefits : 2023-24 Benefit Guide