2024-2025 Insurance Change Form

You may add or cancel benefit coverage during the plan year only if you experience a Qualifying Life Event.

Complete this form and provide a proof documentation for your qualifying event (i.e. marriage/death/birth or hospital certificate, etc.). The proof document must include the date of the qualifying event.

Email the information to HRbenefits@aisd.net within 31 days from the date of your qualifying event.
It is your responsibility to complete this form and provide proof of your qualifying event within 31 days or you will NOT be able to change your benefits until the next annual enrollment period.

Personal Information

Employee Name	Employee SSN
Employee ID Number	Daytime Telephone Number
Qualifying Event Date	

DEPENDENT INFORMATION (Only add the dependent you are adding/removing from coverage)

Name (Last, First)	SSN	Date of Birth	Gender	Relation (S=Spouse, C=Child, H=Handicapped)

QUALIFYING LIFE EVENT REASON

ADDITIONS/DOCUMENTATION NEEDED

- ☐ Marriage: Marriage Certificate
- ☐ Divorce: Divorce Decree
- ☐ Birth: Certificate of Birth or Hospital Certificate
- ☐ Adoption: Placement of Papers of Adoption
- ☐ Loss of Spouse Employment: Letter from employer or carrier
- ☐ Death of Spouse: Death Certificate

DELETIONS/DOCUMENTATION NEEDED

- ☐ Marriage: Marriage Certificate
- ☐ Divorce: Divorce Decree
- ☐ Gain of Spouse Employment: Letter from employer or carrier
- ☐ Dependent Now Ineligible: Letter from Employee
- ☐ Medicare Entitlement: Medicare Letter/copy of Medicare ID card
- ☐ Medicaid Entitlement: Medicaid Award letter
- ☐ Death of Child: Death Certificate
- ☐ Death of Spouse: Death Certificate

2024-2025 Insurance Change Form

SELECT YOUR ENROLLMENT CHANGES
(Mark the benefit and coverage level you are selecting as a result of this Qualifying Life Event)
To enroll a newborn or other dependent only mark the benefits you are electing or changing.

MEDICAL PLAN

Plan: ☐ActiveCare Primary ☐ActiveCare HD ☐ActiveCare Primary+ ☐ ActiveCare 2 *(can only be elected if previously enrolled prior to 9/1/2020)*

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

WELLNESS PROGRAM (there is no cost to participate and members may receive a discount on medical benefits)

☐ YES ☐ NO

HOSPITAL INDEMNITY

Plan: ☐ High $3,00 Plan ☐ Low $1,500 Plan

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

TELE-HEALTH VIRTUAL CARE $0 copay per visit

Plan: ☐ MDLive

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

DENTAL

Plan: ☐ High PPO ☐ Low PPO ☐ DHMO

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

VISION

Plan: ☐ Vison Plan ☐ Enhanced Plan

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

DISABILITY

Waiting Period: ☐ 14 Day ☐ 30 Day ☐ 60 Day ☐ 90 Day

Coverage Level: ☐ 30% of Salary ☐ 40% of Salary ☐ 50% of Salary ☐ 60% of Salary

CANCER

Plan: ☐ High Plan ☐ Low Plan

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

ACCIDENT

Plan: ☐ High Plan ☐ Low Plan

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

GROUP LIFE - EMPLOYEE

☐ Cancel Coverage Level $ _____ (Can elect in increments of $10,000 up to maximum of 7 x's salary or $500,000)

GROUP LIFE - SPOUSE

☐ Cancel Coverage Level $ _____ (Can elect in increments of $5,000 up to maximum of $100,000)

GROUP LIFE - Child

☐ Cancel Coverage Level $ _____ (Can elect in increments of $1,000 up to maximum of $10,000)

2024-2025 Insurance Change Form

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) **Employee is covered at 100%, spouse 50%, eligible child 10%**

Coverage Level – EMPLOYEE

☐ Cancel Coverage Level $ _____ (Can elect in increments of $10,000 up to maximum of 10 X'S SALARY OR $500,000)

Coverage Level - FAMILY

☐ Cancel Coverage Level $ _____ (Can elect in increments of $10,000 up to maximum of 10 X'S SALARY OR $500,000)

IDENTITY THEFT

Plan: ☐ 1 Bureau ☐ Platinum

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

MASA-EMERGENCY TRANSPORTATION

Plan: ☐ Emergent Premier

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

LEGAL SERVICES

Plan: ☐ Metlaw Legal Plan

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

HE**ALTHCARE SAVINGS ACCOUNT (HSA)**

Coverage Level: ☐ Waive (Can elect a minimum $25.00 monthly amount up to a maximum $345.83 individual monthly amount or a maximum $691.67 family monthly amount)

MEDICAL REIMBURSEMENT ACCOUNT (FSA)

Coverage Level: ☐ Waive _____ (Can elect a minimum $25.00 monthly amount up to a maximum $266.66 individual monthly amount or a maximum $541.66 family monthly amount)

DEPENDENT CARE REIMBURSEMENT ACCOUNT

Coverage Level: ☐ Waive _____ (Can elect a minimum $25.00 monthly amount up to a maximum $416.67 monthly amount)

Employee Name _____ **Employee ID** _____

Employee Signature _____ **Date** _____

Please return completed form, along with appropriate documentation to hrbenefits@aisd.net or 682-867-4651 (fax)

2024-2025 Insurance Change Form

TRS ActiveCare Health Insurance Premiums

	TRS ActiveCare Primary	TRS ActiveCare HD	TRS ActiveCare Primary+	TRS ActiveCare 2
12 Pay – Administrators and Professionals				
Employee Only	**$239.00**	**$253.00**	**$326.00**	**$747.00**
Employee + Spouse	**$1,098.00**	**$1,136.00**	**$1,274.00**	**$2,136.00**
Employee + Children	**$593.00**	**$617.00**	**$741.00**	**$1,241.00**
Family	**$1,451.00**	**$1,499.00**	**$1,688.00**	**$2,575.00**
12 Pay – Para-Professionals				
Employee Only	**$224.00**	**$238.00**	**$311.00**	**$732.00**
Employee + Spouse	**$1,083.00**	**$1,121.00**	**$1,259.00**	**$2,121.00**
Employee + Children	**$578.00**	**$602.00**	**$726.00**	**$1,226.00**
Family	**$1,436.00**	**$1,484.00**	**$1,673.00**	**$2,560.00**
18 Pay				
Employee Only	**$149.33**	**$158.67**	**$207.33**	**$488.00**
Employee + Spouse	**$722.00**	**$747.33**	**$839.33**	**$1,414.00**
Employee + Children	**$385.33**	**$401.33**	**$484.00**	**$817.33**
Family	**$957.33**	**$989.33**	**$1,115.33**	**$1,706.67**
26 Pay				
Employee Only	**$103.38**	**$109.85**	**$143.54**	**$377.85**
Employee + Spouse	**$499.85**	**$517.38**	**$581.08**	**$978.92**
Employee + Children	**$266.77**	**$277.85**	**$335.08**	**$565.85**
Family	**$662.77**	**$684.92**	**$772.15**	**$1,181.54**

AISD contributes the following each month to employees participating in a medical plan:

- $266 per month for Professional employees
- $281 per month for all Para-Professional and Auxiliary employees