

# EMPLOYEE BENEFITS

## MID-YEAR QUALIFYING EVENT CHANGES

(Revised 1/24/2012)

**INSTRUCTIONS:** The Change or Enrollment Form **MUST** be presented to the Insurance Department **NO LATER THAN 30 DAYS** after the qualifying event date. All required documentation (see below) of the qualifying event **MUST** be submitted **WITH** the appropriate Change/Enrollment Form(s) **to the Insurance Department at ISC-North, Suite 136.**  
*(If in doubt as to what type of documentation is required call the Insurance Department at (281) 897-4138.)*

**TERMINATION OF COVERAGE NOTICE:** TRS-ActiveCare plans through Blue Cross Blue Shield (BCBS), Scott & White, and FirstCare HMOs **will not permit retroactive voluntary termination dates.** Although you have 30 days from the qualifying event to present your change documents, all voluntary terminations will be effective on the last day of the month **following the Insurance Department's receipt of your written documentation.**

**Your spouse's Annual Enrollment Period,** may qualify you to make a prospective election change to terminate your CFISD benefit elections and enroll in your spouse's plan, if your spouse's employer's plan offers better premiums, deductible, copayments, and/or other benefits. You must submit to the Insurance Department a plan Change Form (see below) and a written request for the change containing information relative to the change you wish to make sufficient for the Plan Administrator to determine that the criteria for such a change has been satisfied and is in accordance with applicable law and regulations. Your spouse's Annual Enrollment Period **WILL NOT** qualify you to enroll in a CFISD plan mid-year.

**ENROLLMENT NOTICE: If you are enrolling in TRS-ACTIVECARE medical insurance because you have recently lost coverage through another plan you must submit the following:**

- 1.) TRS-ActiveCare Enrollment Application and Change Form. (on the Insurance Department's web page)
- 2.) A letter (or COBRA notice) from your former plan stating the following:
  - a. The date your coverage was terminated
  - b. The reason your coverage was terminated
- 3.) Your Certificate of Creditable Coverage (COCC) (required to be sent to you by your former insurer within 15 days of your termination of coverage.) The certificate must also include the enrollment history of all dependents for whom you are requesting coverage. We cannot process your enrollment without receipt of your and your dependents' COCC.

### **DENTAL AND VISION and Other Optional Insurance Plan Changes:**

Requesting a change to your medical insurance coverage **DOES NOT AUTOMATICALLY** authorize a corresponding change to your **DENTAL OR VISION** plans or other benefits. **You will need to complete and submit the appropriate forms.** Attached to this document are the Change Forms for the Assurant Indemnity Dental Plan, the Heritage PrePaid DHO Dental Plan, and the Guardian Vision Insurance Plan. For all other plans you will need to go to the "Your Benefit Station" link on the District's Insurance Department web page. The effective date of change in coverage will be the first or last day of the month following the Insurance Department's receipt of your change form(s) and qualifying event documentation, depending on the change you wish to make.

### **WRITTEN DOCUMENTATION OF THE QUALIFYING EVENT THAT MUST BE SUBMITTED WITH THE CHANGE FORM(S)**

**Job Change** A letter from the new or former employer stating:

- (1) the date of hire or the date of termination of employment;
- (2) the date benefits will become effective or will be terminated;
- (3) the names of persons who will be covered under the new employer's plan, or whose coverage has been terminated;
- (4) the type of coverage (Medical, Dental, and/or Vision) you maintained with your former insurer.

**NOTE:** You will only be allowed to insure person(s) previously covered by other insurance who have lost their coverage due to the job change. You cannot add additional dependents until our Annual Enrollment Period (currently in the Spring for a September 1, effective date).

**Effective Date:** The first day of the month following the coverage termination date indicated on the above required letter.

**Termination Date:** The last day of the month following the Insurance Department's receipt of your Change Form and qualifying event documentation.

- Birth  
NEW  
9/1/2011**      **Effective 9/1/2011** – Under the TRS-ActiveCare guidelines, the employee has 60 days after the newborn’s date of birth to enroll the newborn for coverage. If the employee has employee and child(ren) or employee and family coverage at the time of the newborn’s birth and at the time of enrollment, the employee has up to one year after the newborn’s date of birth to add the newborn to coverage. The spouse and other eligible dependents can only be added within 31 days after the newborn’s date of birth. A copy of the “unofficial” birth certificate with the footprints from the hospital or a copy of the “Birth Facts” Sheet from the hospital is sufficient, as long as it is signed by a hospital official and it includes the baby’s name, parents’ names, and date of birth.  
**Effective Date: Retroactive to the date of birth.**  
**NOTE:** We will also need a Social Security Number for your newborn. If you have not received it by the time of enrollment, please forward the Social Security Number to the Insurance Department as soon as possible.
- Adoption  
or  
Foster Care  
Placement**      A copy of the “placement authorization” from the adoption agency, Child Protective Services, or the court.  
**NOTE:** We will also need a Social Security Number for the child. If you have not received it by the time of enrollment, please forward the Social Security Number to the Payroll Department as soon as possible.  
**Effective Date:** Retroactive to the date of the child’s placement in the employee’s home.
- Marriage**      **To add new spouse and/or newly acquired stepchildren:** Either a copy of the marriage certificate or a copy of the signed marriage license.  
**Effective Date:** The first day of the month following the Insurance Department’s receipt of your Change Form and qualifying event documentation.  
**NOTE:** A letter or church sacramental certificate signed by the wedding official can also be used for documentation.  
**To terminate your own coverage:** Same as above **PLUS** documentation from your new spouse’s plan (medical and/or dental) that you have been enrolled.  
**Termination Date:** The last day of the month following the Insurance Department’s receipt of your Change Form and qualifying event documentation.
- Divorce**      **To terminate your former spouse’s coverage:** Copies of the first and last pages of your certified divorce decree, signed by the judge.  
**Termination Date:** Last day of the month following the Insurance Department’s receipt of your Change Form and qualifying event documentation.  
**NOTE:** Do not wait for a copy from your attorney’s office. You have only 30 days from the date of your divorce to make your plan changes. You are advised to purchase a certified copy of your decree from the courthouse as soon as it is available (usually 1-2 weeks after your court date.) *(Please provide your former spouse’s current address. We are required by law to send him/her a COBRA extension of coverage notice.)*  
**To enroll in coverage:** Same as above **PLUS** documentation that your former spouse’s plan has terminated your coverage because of the divorce, along with the Certificate of Creditable Coverage they are required to send to you within 15 days of your termination of coverage..  
**Effective Date:** The first day of the month following the date your former spouse’s plan terminated your coverage because of the divorce.
- Death**      **To terminate the deceased’s coverage:** Either a copy of the death certificate or the obituary.  
**Termination Date:** The last day of the month following the death.  
**To enroll in coverage:** Same as above **PLUS** documentation that your deceased spouse’s plan has terminated your coverage because of his/her death.  
**Effective Date:** The first day of the month following the date your spouse’s plan terminated your coverage because of his death.
- Age  
Ineligibility**      **Effective on the dependent child’s 26<sup>th</sup> birthday.** A copy of the dependent’s birth certificate or driver’s license. *(Please provide the terminating dependent’s current address. We are required to send him/her a COBRA extension of coverage notice.)*  
**Termination Date:** Last day of the month following the qualifying event date.
- Other:**      Call or visit the Insurance Department at (281) 897-4138, ISC-North, Suite 136.
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Please print in blue or black ink.

**Enrollment Application and Change Form**

Group Number 085000

www.trs.state.tx.us/trs-activecare

**ELIGIBILITY**

Are you actively employed and making monthly contributions to TRS?  Yes  No  
If no, are you regularly scheduled to work 10 or more hours per week?  Yes  No (if no to both, you are not eligible for TRS-ActiveCare coverage.)

**SECTION 1 — ENROLLMENT EVENTS** Check all that apply

**District/Employer Name**

New Enrollee  Add Dependent  
Are you applying as a result of:  
Annual Enrollment?  Yes  No  
Special Enrollment Event?  Yes  No  
If yes, indicate event date: MM DD YYYY  
Event:  Marriage  Birth or Adoption  
 Court Order  Loss of Other Coverage  
 Other, Explain: \_\_\_\_\_

If you are a new hire, when do you want coverage to begin?  
 Actively-at-work date  
 First of the month following the actively-at-work date

Cancel Enrollee  Cancel Dependent  
List names of those canceling in Section 5  
Event:  Divorce\*  Death\*  Loss of Eligibility  
 Terminated Employment or Retirement  
 Non-Payment of Premium  
 Leave of Absence Period Expired  
 Dropped Coverage (Employee Request)  
 Other Explain: \_\_\_\_\_  
Indicate event date: MM DD YYYY

Change  
 Plan/Coverage  
 Address  
 Name

Declining Coverage (Complete Sections 2 & 9)

**For Employer Use Only**

TRS Reporting Number: \_\_\_\_\_

Employee's Actively-at-Work Date: \_\_\_\_\_

Effective Date of Coverage: MM DD YYYY

Employer Verification Signature: \_\_\_\_\_

**SECTION 2 — PLEASE TELL US ABOUT YOURSELF** Complete even if declining coverage

Male  Married  Single  
 Female  Single  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth Date: MM DD YYYY Social Security Number: \_\_\_\_\_ Work Phone Number: ( ) ( ) Home Phone Number: ( ) ( )

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home E-Mail Address: \_\_\_\_\_

**Complete only if you are applying for HMO Coverage**

Primary Language: \_\_\_\_\_ Do you have a disability affecting your ability to communicate or read:  Yes  No Describe special communication materials needed: \_\_\_\_\_ PCP Number for HMO: \_\_\_\_\_

FEMALE enrollees: You have the right to designate an OB/GYN physician to whom you have access without first obtaining a referral from your Primary Care Physician. You are not required to designate an OB/GYN; you may elect to receive your OB/GYN services from your PCP. If you wish to designate an OB/GYN physician, please list the provider number. OB/GYN Number for HMO: \_\_\_\_\_

**SECTION 3 — MEDICARE INFORMATION** Complete if you or any dependents are covered by Medicare (Attach another application if more space is needed)

Name of person covered: \_\_\_\_\_ HIC# (from ID card): \_\_\_\_\_

Medicare Part A (hospital) Start Date: MM DD YYYY End Date: MM DD YYYY  
 Medicare Part B (medical) Start Date: MM DD YYYY End Date: MM DD YYYY

Medicare Part C  w/drugs OR  without drugs Start Date: MM DD YYYY End Date: MM DD YYYY  
 Medicare Part D (prescription drugs) Start Date: MM DD YYYY End Date: MM DD YYYY

Check reason for Medicare eligibility:  Entitled age  Entitled disability  End-stage renal disease  Disability and current renal disease

**SECTION 4 — SELECT YOUR PLAN AND COVERAGE CATEGORY**

**Health Benefits Plan (Check one)**  
PPO:  ActiveCare 1-HD  ActiveCare 1  ActiveCare 2  ActiveCare 3  
HMO:  FirstCare  Scott & White Health Plan  Valley Baptist Health Plans

**Coverage Category (Check one)**  
 Employee Only  
 Employee and Spouse  
 Employee and Child(ren)  
 Employee and Family

**SECTION 5 — DEPENDENT COVERAGE** Complete to apply for or make changes to dependent coverage

**Spouse**  Add  Drop  Male  Female Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ PCP Number for HMO: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth Date: MM DD YYYY Mailing Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Child**  Add  Drop  Male  Female Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ PCP Number for HMO: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth Date: MM DD YYYY Mailing Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Indicate child's relationship to employee:  Natural/adopted child  Stepchild  Foster child  Legal guardianship  Grandchild\*\*  Other child\*\*

**Child**  Add  Drop  Male  Female Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ PCP Number for HMO: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth Date: MM DD YYYY Mailing Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Indicate child's relationship to employee:  Natural/adopted child  Stepchild  Foster child  Legal guardianship  Grandchild\*\*  Other child\*\*

\* HMO enrollees may be eligible for state continuation coverage. See your Evidence of Coverage for more information.  
\*\* Must meet eligibility criteria specified in the first bullet under Coverage Conditions in Section 10.

If additional space for dependents is needed, see reverse side.

**SECTION 5 — DEPENDENT COVERAGE (continued)** Complete to apply for or make changes to dependent coverage

<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
Indicate child's relationship to employee: <input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> Other child**						

<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
Indicate child's relationship to employee: <input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> Other child**						

<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
Indicate child's relationship to employee: <input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> Other child**						

\*\* Must meet eligibility criteria specified in the first bullet under Coverage Conditions in Section 10. If additional space for dependents is needed, attach another application.

**SECTION 6 — PREVIOUS COVERAGE INFORMATION** This does not apply to those who enroll when first eligible, new hires or HMO enrollees.

In order to receive credit for preexisting condition waiting periods, you must provide information about prior creditable coverage for you and any dependents listed. (If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19. If Medicare, please complete the Medicare information in Section 3 on the front of the application.

**SECTION 7 — OTHER HEALTH COVERAGE INFORMATION**

Are you or any of your dependents who are enrolling for any TRS-ActiveCare plan covered by any other health coverage?  Yes  No  
If yes, please list names of every individual covered by another health plan.

**SECTION 8 — DISABLED DEPENDENT CHILD** Complete for disabled children and submit Dependent Child's Statement of Disability

Name of Disabled Dependent Child	Nature of Disability
Has disability been diagnosed as permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No If temporary, how long is disabled dependent child expected to remain disabled?	Is disabled dependent child unable to work due to the disability? <input type="checkbox"/> Yes <input type="checkbox"/> No

A dependent Child's Statement of Disability form is also required to enroll a disabled dependent child age 25 or over (age 26 or over, effective September 1, 2011). See your Benefits Administrator.

**SECTION 9 — DECLINING HEALTH COVERAGE** To decline coverage, Section 2 must also be completed

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a preexisting condition exclusion period (not applicable to HMO coverage). Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19.

Name <input type="checkbox"/> Employee	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
Name <input type="checkbox"/> Spouse	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 10 — COVERAGE CONDITIONS**

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) afforded by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, with HMO benefits provided by SHA, L.L.C. dba FirstCare, Scott and White Health Plan, and Valley Baptist Insurance Company dba Valley Baptist Health Plans. On behalf of myself and any dependents listed on this Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
- If I am enrolling a grandchild in Section 5, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
- If I am enrolling a child as an "other child" in Section 5, I certify that my household is the child's primary residence, that I provide at least 50% of the child's support, that neither of the child's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions of the TRS-ActiveCare program.
- If I am enrolling a child as an "other child" in Section 5, I understand that the health coverage I am applying for may be subject to a preexisting condition exclusion (not applicable to HMO coverage). Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19.
- I understand that by enrolling for coverage with the Employer named in this Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that if I terminate TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on this Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Group # B550

Code Change \_\_\_\_\_ > \_\_\_\_\_  
Effective Date: \_\_\_\_\_

**ASSURANT BENEFITS INSURANCE CO.**  
**DENTAL (INDEMNITY) PLAN**  
*Cypress - Fairbanks I.S.D. Change Form*

Employee Name: \_\_\_\_\_ Soc.Sec.No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last (new, if changed) First MI

Employee #: \_\_\_\_\_ Campus/Building Assignment: \_\_\_\_\_

Occupation: \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INDICATE CHANGE TO BE MADE BELOW**

\_\_\_\_ Name Change: \_\_\_\_\_ >Change to> \_\_\_\_\_  
Prior Last Name New Last Name

\_\_\_\_ Address Change: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_ **Cancel** ALL Coverage    \_\_\_\_ **Add** Dependents listed below    \_\_\_\_ **Cancel** Dependents listed below

List of Dependents (List *ONLY* those dependents affected by this change.):

Name	Relation to Employee	Sex M/F	Social Security Number	Date of Birth
_____	<u>Spouse</u>	_____	_____ - _____ - _____	____/____/____
_____	_____	_____	_____ - _____ - _____	____/____/____
_____	_____	_____	_____ - _____ - _____	____/____/____
_____	_____	_____	_____ - _____ - _____	____/____/____
_____	_____	_____	_____ - _____ - _____	____/____/____

**Change Because of:**

____ Annual Enrollment *	Date _____	____ Death*	Date _____
____ Marriage *	Date _____	____ Age Ineligibility *	Date _____
____ Birth or Adoption *	Date _____	____ Job Change *	Date _____
____ Divorce *	Date _____	____ Other	Date _____
____ Job Termination *	Date _____		

- Written documentation of this "change of family status" is required to be submitted with the Change Form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Group # B550

Code Change \_\_\_\_\_ > \_\_\_\_\_  
Effective Date: \_\_\_\_\_

*Cypress -Fairbanks I.S.D. Change Form*  
**Heritage PrePaid DHMO Dental Plan**

Employee Name: \_\_\_\_\_ Soc.Sec.No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last(new, if changed) First MI

Employee #: \_\_\_\_\_ Campus/Building Assignment: \_\_\_\_\_

Occupation: \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**INDICATE CHANGE TO BE MADE BELOW**

\_\_\_\_ Name Change: \_\_\_\_\_ >Change to> \_\_\_\_\_  
Prior Last Name New Last Name

\_\_\_\_ Address Change: \_\_\_\_\_

\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_ **Cancel** ALL Coverage    \_\_\_\_ **Add** Dependents listed below    \_\_\_\_ **Cancel** Dependents listed below

List of Dependents (List *ONLY* those dependents affected by this change.):

Name	Relation to Employee	Sex M/F	Social Security Number	Date of Birth	DDS Name	DDS ID#
_____	<u>Spouse</u>	_____	_____ - _____ - _____	____ / ____ / ____	_____	_____
_____	_____	_____	_____ - _____ - _____	____ / ____ / ____	_____	_____
_____	_____	_____	_____ - _____ - _____	____ / ____ / ____	_____	_____
_____	_____	_____	_____ - _____ - _____	____ / ____ / ____	_____	_____
_____	_____	_____	_____ - _____ - _____	____ / ____ / ____	_____	_____

**Change Because of:**

____ Annual Enrollment	Date _____	____ Death*	Date _____
____ Marriage *	Date _____	____ Age Ineligibility *	Date _____
____ Birth or Adoption *	Date _____	____ Job Change *	Date _____
____ Divorce *	Date _____	____ Other	Date _____
____ Job Termination	Date _____		

- Written documentation of this "change of family status" is required to be submitted with this Change Form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please print clearly to ensure accurate processing



Employer: Cypress-Fairbanks I.S.D. 10300 Jones Road Houston, TX 77065

Guardian Group Plan Number: 00460832

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY New Application Add Dependent(s) Drop Dependent(s) Change Address Change Name Drop Coverage as of: / / Class Hours Worked Division Benefits Effective / / All Eligible Employees Keep a copy for your records and return form to: Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012

ABOUT YOURSELF First, Middle Initial, Last Name Add Change Drop Sex Date of Birth (mm/dd/yyyy) Social Security Number M F / / / / Address City State Zip Preferred E-mail Day Phone Eve Phone The best way to reach you: E-mail Day Phone Eve Phone Job Title Work Status Date work status began Full-Time Part-Time Retired COBRA/State Continuation / / Are you married? Yes No Do you have children or other dependents? Yes No What is your primary language? Do you have a disability, which would affect your ability to communicate or read? Yes No

ABOUT YOUR DEPENDENTS A sheet with information about applying for dependents is attached. Spouse First, Middle Initial, Last Name Add Change Drop Sex Date of Birth (mm/dd/yyyy) Social Security Number Marriage Date (mm/dd/yyyy) M F / / / / Child 1 Add Change Drop Sex Date of Birth (mm/dd/yyyy) Full-time student, at (school): City/State: Attending Since / / Child 2 Add Change Drop Sex Date of Birth (mm/dd/yyyy) Full-time student, at (school): City/State: Attending Since / / Child 3 Add Change Drop Sex Date of Birth (mm/dd/yyyy) Full-time student, at (school): City/State: Attending Since / / Child 4 Add Change Drop Sex Date of Birth (mm/dd/yyyy) Full-time student, at (school): City/State: Attending Since / / To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages. Vision

**CHOOSE YOUR VISION COVERAGE**

*Insurance (for only)*

Your monthly premium	Full Feature		
Employee alone	<input type="checkbox"/> \$9.88		<input type="checkbox"/> I waive this coverage
Employee and Spouse	<input type="checkbox"/> \$16.62		<input type="checkbox"/> I waive this coverage
Employee and Child(ren)	<input type="checkbox"/> \$16.96		<input type="checkbox"/> I waive this coverage
Entire family	<input type="checkbox"/> \$26.84		<input type="checkbox"/> I waive this coverage

If you are waiving coverage, are you covered under another vision plan?  Yes  No

If you are waiving dependent coverage, are your dependents covered under another vision plan?  Yes  No

**IMPORTANT NOTES**

- If I have waived the vision coverage, and elect coverage at a later date, enrollment delays may apply.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan's next annual vision enrollment period.

**SIGNATURE**

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE **X**

DATE