

# Brevard Public Schools - Benefit Change Form 2019

**Select one of the following boxes:**

Qualifying Event (QE)     
  Job Share     
  Former Retiree     
  First Day of Unpaid Leave     
  Return from Unpaid Leave  
 Reason for request: \_\_\_\_\_

**NOTE:** ALL CHANGE REQUESTS **MUST** BE RECEIVED BY THE EMPLOYEE BENEFITS OFFICE WITHIN 30 DAYS FOLLOWING THE DATE OF THE EVENT **AND** BE ACCOMPANIED BY SUPPORTING DOCUMENTATION.

Name \_\_\_\_\_ Employee ID # \_\_\_\_\_ Site # \_\_\_\_\_

(Leave "Effective Date" blank. The Employee Benefits Office will determine) Effective Date \_\_\_\_\_

**NOTE:** One benefit-eligible employee may not elect medical\* coverage for another benefit-eligible employee who is their spouse but may cover another benefit-eligible employee who is their child (up to age 26). \*(However, coverage for dental and vision may be elected.)

***\*Only mark the benefits you wish to change. Leave the rest blank\****

Premiums listed on this enrollment form are **MONTHLY** amounts

To calculate your per-pay cost, multiply the premium cost shown below by 12 then divide that amount by your pay frequency

## MEDICAL

No Coverage -- I do not want Medical Coverage

Pre-tax	Employee Only Cost	Employee + SPOUSE* Cost	Employee + Children Cost	Employee + Family* Cost
			<small>(Does not include coverage for dep 26-30)</small>	
<b>BPS Health Plan</b>	<input type="checkbox"/> 106.67	<input type="checkbox"/> 443.87	<input type="checkbox"/> 278.27	<input type="checkbox"/> 561.47

**To cover Dependents of age 26-30 (non-disabled)**  
 - You must complete a Dependent 26-30 (non-disabled) Affidavit for each 26-30 dependent  
 - In addition to your tier on the left, mark the box below as the tiers do not include the Dep 26-30 surcharge

358.88  
 Only this tier is post-tax

\* If adding a **SPOUSE** to medical coverage:  
 -A surcharge may apply; YOU must complete and attach the Spousal Affidavit  
 -Spouse must complete biometric & health assessment by 11/15/19 for a reduced Family deductible in '20

## DENTAL

No Coverage -- I do not want Dental Coverage

Pre-tax	Employee Only Cost	Employee Plus One Cost	Employee Plus Two or More Cost		Employee Plus One Cost	Employee Plus Two or More Cost
<b>DeltaCare HMO - M74 Low</b>	<input type="checkbox"/> 7.30	<input type="checkbox"/> 12.07	<input type="checkbox"/> 17.85	<small>Facility # for employee</small>	<input type="checkbox"/> 12.07	<input type="checkbox"/> 17.85
<b>DeltaCare HMO - 15B High</b>	<input type="checkbox"/> 12.60	<input type="checkbox"/> 23.41	<input type="checkbox"/> 34.19		<input type="checkbox"/> 23.41	<input type="checkbox"/> 34.19
<b>PPO - Low</b>	<input type="checkbox"/> 24.97	<input type="checkbox"/> 50.50	<input type="checkbox"/> 74.70		<input type="checkbox"/> 50.50	<input type="checkbox"/> 74.70
<b>PPO - High</b>	<input type="checkbox"/> 31.81	<input type="checkbox"/> 64.20	<input type="checkbox"/> 94.82		<input type="checkbox"/> 64.20	<input type="checkbox"/> 94.82

*Dependent 26-30 (non-disabled) affidavit required (Your entire deduction will now be post-tax)*

## VISION

No Coverage -- I do not want Vision Coverage

Pre-tax	Employee Only Cost	Employee Plus One Cost	Employee Plus Two or More Cost		Employee Plus One Cost	Employee Plus Two or More Cost
<b>Basic</b>	<input type="checkbox"/> 4.45	<input type="checkbox"/> 11.08	<input type="checkbox"/> 18.99		<input type="checkbox"/> 11.08	<input type="checkbox"/> 18.99
<b>Enhanced</b>	<input type="checkbox"/> 6.72	<input type="checkbox"/> 16.69	<input type="checkbox"/> 28.62		<input type="checkbox"/> 16.69	<input type="checkbox"/> 28.62

*Dependent 26-30 (non-disabled) affidavit required (Your entire deduction will now be post-tax)*

## BASIC EMPLOYEE LIFE INSURANCE

Pre-tax (1 times your annual salary in life insurance is paid by the School Board at no cost to you.)  One times pay       No Coverage

## ADDITIONAL EMPLOYEE LIFE INSURANCE

Post-tax  No Coverage -- I do not want Additional Life Coverage

1 x Pay     
  2 x Pay     
  3 x Pay     
  4 x Pay     
 Can only increase by 1x if QE is marriage, birth, or if returning from an unpaid leave.

# Benefit Change Form 2019 (cont.)

## ACCIDENTIAL DEATH & DISMEMBERMENT

No Coverage (When you cover dependents, you are the primary beneficiary)

Post-tax

1 x Pay   
  2 x Pay   
  3 x Pay   
  4 x Pay   
  Add on Dependent 26-30  
*Need to select in addition to above*   
 Employee Only   
 Employee + Family   
 Dependent 26-30 (non-disabled) affidavit needed

## DEPENDENT LIFE INSURANCE

No Coverage (When you cover dependents, you are the primary beneficiary)

Post-tax

<input type="checkbox"/>	3.01	Spouse \$5,000; and each eligible child \$2,500	<b>-or- if only covering child/ren for \$2,500 then select this option</b>
<input type="checkbox"/>	5.83	Spouse \$10,000; and each eligible child \$2,500	<input type="checkbox"/> Add on Dependent 26-30
<input type="checkbox"/>	12.76	Spouse \$25,000; and each eligible child \$2,500	Dependent 26-30 (non-disabled) affidavit needed
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<input type="checkbox"/>	3.26	Spouse \$5,000; and each eligible child \$5,000	<b>-or- if only covering child/ren for \$5,000 then select this option</b>
<input type="checkbox"/>	6.08	Spouse \$10,000; and each eligible child \$5,000	<input type="checkbox"/> Add on Dependent 26-30
<input type="checkbox"/>	13.01	Spouse \$25,000; and each eligible child \$5,000	Dependent 26-30 (non-disabled) affidavit needed

## DISABILITY INSURANCE

**NO CHANGES ALLOWED**

Post-tax

Short Term Disability (Salary Sensitive)  
 Long Term Disability (Salary and Age Sensitive)

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HC FSA)

Pre-tax

Must enter the **PER PAY** amount **YOU WANT** to contribute (Maximum \$2,600.00 for the year)  
 Employee Contribution \$ \_\_\_\_\_   
  No Contribution

## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC FSA)

(this benefit is to be used for **day-care** expenses)

Pre-tax

Must enter the **PER PAY** amount **YOU WANT** to contribute (Maximum \$5,000.00 for the year)  
 Employee Contribution \$ \_\_\_\_\_   
  No Contribution

### Dependents to be Insured (Complete for each newly-added dependent)

\* If adding a **SPOUSE** to **medical** coverage:  
 - A surcharge may apply; **YOU** must complete and attach the Spousal Affidavit  
 - Spouse must complete biometric screening & health assessment by 11/15/19 for a reduced Family deductible in '20

Dependent Legal Name	Social Security Number	Date of Birth	Relationship	Medical	Dental	Vision	AD&D	Dep Life	DeltaCare Facility #

**Please Read then Sign Below:** My signature below affirms that all information and statements provided on this form are true to the best of my knowledge. Because of rounding formulas used in this system, there may be some variation in final amounts.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Florida Statute 817.234 - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

**E-mail, fax or send original, with required documents and affidavits, if applicable, to the Office of Employee Benefits at ESF**