Brevard Public Schools - Benefit Change Form 2020

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
		(Does not include coverage for dep 26-30)		
BPS Health Plan	☐ 106.67	☐ 443.87	☐ 278.27	☐ 561.47

* 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

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 amount is *post*-tax

DENTAL

☐ **No Coverage -- I do not want Dental Coverage**

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

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
DeltaCare HMO - M74 Low	☐ 7.30	☐ 12.07	☐ 17.85	Facility # for employee	☐ 12.07	☐ 17.85
DeltaCare HMO - 15B High	☐ 12.60	☐ 23.41	☐ 34.19	Facility # for employee	☐ 23.41	☐ 34.19
PPO - Low	☐ 24.97	☐ 50.50	☐ 74.70		☐ 50.50	☐ 74.70
PPO - High	☐ 31.81	☐ 64.20	☐ 94.82		☐ 64.20	☐ 94.82

VISION

☐ **No Coverage -- I do not want Vision Coverage**

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

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
Basic	☐ 4.45	☐ 11.08	☐ 18.99	☐ 11.08	☐ 18.99
Enhanced	☐ 6.72	☐ 16.69	☐ 28.62	☐ 16.69	☐ 28.62

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

☐ **No Coverage -- I do not want Additional Life Coverage**

Post-tax

☐ 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.

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Benefit Change Form 2020 *(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

☐ 3.01 Spouse $5,000; and each eligible child **$2,500** **-or - if only covering child/ren for $2,500 then select this option**

☐ 5.83 Spouse $10,000; and each eligible child $2,500 ☐ Add on Dependent 26-30

☐ 12.76 Spouse $25,000; and each eligible child $2,500 Dependent 26-30 (non-disabled) affidavit needed

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☐ 3.26 Spouse $5,000; and each eligible child **$5,000** **-or- if only covering child/ren for $5,000 then select this option**

☐ 6.08 Spouse $10,000; and each eligible child $5,000 ☐ Add on Dependent 26-30

☐ 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 $2,700.00 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