2021 Benefit Change Form – Brevard Public Schools

IMPORTANT INFORMATION:

- Change requests must be received in the Employee Benefits Office within 30 days of the qualifying event and include all supporting documentation. Documents may be uploaded to your secure document center in www.easybenefits.com. In your Account tab, select Manage Document Uploads. Call (321) 633-1000, Ext. 11216 should you need assistance.
- If two benefit-eligible BPS employees are married to one another, they may elect dental and vision coverage on each other, but may not elect medical, life or AD&D coverage on each other.
- A benefit-eligible BPS employee may cover another benefit-eligible employee who is their child (up to age 26) for all coverage.
- If enrolling in medical coverage, for yourself or yourself and spouse, you must also complete a **Medical Plan Affidavit** regarding:
  - ***Tobacco use*** - a $50/month *tobacco-use surcharge* (post tax) may apply
  - ***Your Spouse's employment/insurance status*** - a $250/month (post tax) *spousal surcharge* may apply
- To cover a ***dependent age 26-30*** (non-disabled), you must also complete a **Dependent 26-30 (Non-Disabled) Affidavit**.
  Medical – If eligible for coverage, an Over-age dependent surcharge of $358.88/month (post-tax) will apply.
  Dental and Vision – If eligible for coverage, your entire premium deduction becomes post-tax.
- You may update your life insurance beneficiaries 24/7 at www.easybenefits.com.

Employee Name: _____ Employee ID #: _____ Site #: _____

Effective Date: _____ (Leave blank. For Employee Benefits Office use only).

Reason for Request (check one):

❑ Qualifying Event (explain): _____

❑ First Day of Unpaid Leave ❑ Return from Unpaid Leave ❑ Former Retiree ❑ Job Share ❑ Overage Dependent

Premiums listed on this form are MONTHLY amounts.
To calculate your per-pay cost, multiply the premium cost shown below by 12, then divide by your pay frequency.

MEDICAL ❑ Cancel ❑ Change ❑ No Change

Pre-tax

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Silver Plan	❑ $106.67	❑ $443.87	❑ $278.27	❑ $561.47
Gold Plan	❑ $132.67	❑ $523.87	❑ $328.27	❑ $651.47

A **Medical Plan Affidavit** must be completed by the employee if enrolling themself/spouse in medical coverage.
A ***Spousal Surcharge*** of $250 monthly (post-tax) may apply. A ***Tobacco Use Surcharge*** of $50 monthly (post-tax may apply).

An ***Overage Dependent Surcharge*** of $358.88 monthly (post-tax) will apply for each dependent child age 26-30 on medical coverage.

DENTAL ❑ Cancel ❑ Change ❑ No Change

Pre-tax

	Employee Only	Employee + One	Employee + 2 or More	
DeltaCare HMO - M74 Low	❑ $7.30	❑ $12.07	❑ $17.85	**Provider Facility #: _____**
DeltaCare HMO – 15B High	❑ $12.60	❑ $23.41	❑ $34.19	**Provider Facility #: _____**
Delta Dental PPO – Low	❑ $24.97	❑ $50.50	❑ $74.70	
Delta Dental PPO – High	❑ $31.81	❑ $ 64.20	❑ $94.82	

VISION ❑ Cancel ❑ Change ❑ No Change

Pre-tax

	Employee Only	Employee + One	Employee + 2 or More
Humana – Basic	❑ $4.45	❑ $11.08	❑ $18.99
Humana – Enhanced	❑ $6.72	❑ $16.69	❑ $28.62

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BASIC EMPLOYEE LIFE INSURANCE

❑ Cancel ❑ Elect ❑ No Change

Pre-tax

One times annual pay. No cost to actively working employee; premiums are paid by the School Board.

ADDITIONAL EMPLOYEE LIFE INSURANCE

❑ Cancel ❑ Change ❑ No Change

Post-tax

Changes allowed for marriage, birth, or return from unpaid leave. You may elect new coverage at 1 x pay or increase existing coverage by 1 x pay.

❑ 1 x Pay ❑ 2 x Pay ❑ 3 x Pay ❑ 4 x Pay

ACCIDENTAL DEATH & DISMEMBERMENT

❑ Cancel ❑ Change ❑ No Change

Post-tax

Select tier: ❑ Employee Only ❑ Employee + Family
and
Select coverage: ❑ 1 x Pay ❑ 2 x Pay ❑ 3 x Pay ❑ 4 x Pay

DEPENDENT LIFE INSURANCE

❑ Cancel ❑ Change ❑ No Change

Post-tax

- ❑ $3.01 - Spouse $5,000; and each eligible child $2,500
- ❑ $5.83 - Spouse $10,000; and each eligible child $2,500
- ❑ $12.76 - Spouse $25,000; and each eligible child $2,500
- ❑ $3.26 - Spouse $5,000; and each eligible child $5,000
- ❑ $6.08 - Spouse $10,000; and each eligible child $5,000
- ❑ $13.01 - Spouse $25,000; and each eligible child $5,000

SHORT TERM DISABILITY

❑ Cancel ❑ No Change

Post-tax

Application for coverage is only allowed during open enrollment. If coverage is canceled and later applied for during open enrollment, the insurance carrier will require evidence of insurability to determine approval/denial of coverage.

LONG TERM DISABILITY

❑ Cancel ❑ No Change

Post-tax

Application for coverage is only allowed during open enrollment. If coverage is canceled and later applied for during open enrollment, the insurance carrier will require evidence of insurability to determine approval/denial of coverage.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

❑ Cancel ❑ Change ❑ No Change

Pre-tax

Enter the amount you want to contribute PER PAY CHECK: $_____ (Maximum annual contribution is $2,750)

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

❑ Cancel ❑ Change ❑ No Change

Pre-tax

Enter the amount you want to contribute PER PAY CHECK: $_____ (Maximum annual contribution is $5,000)

DEPENDENTS TO BE INSURED - Complete for each dependent you are adding to coverage

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

My signature below affirms that all information and statements provided on this form are true to the best of my knowledge.

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.