

ETXEBC—

New Hire Enrollment Qualifying Event Termination COBRA Elections

1 Employee Information

Employee Name: _____ Gender: _____ Date of Birth: (m/d/yr) _____ Social Security Number: _____
 Male / Female / / - -

Home Address: (Street, Apt #) _____ City: _____ State: _____ Zip: _____ Home Phone #: _____ Email Address: _____
 - -

2 Payroll Information

Annual Salary: _____ Pay Frequency: (9,10,12,24 etc.) _____ Date Of Hire: _____ Benefit Effective Date: _____
 / / / /

3 Qualifying Event Change

You may add or cancel coverage during the Section 125 Plan Year if you have a qualifying event and you notify the Benefits Department within 31 days of the change. Documentation, proof, and Administrator's signature are required with this form. Please complete all information.

Reason for Request: Marriage or Divorce Death of Spouse or Dependent Birth or Adoption of a Child Job Status Change for Employee or Spouse
 Termination / Commencement of Employment Self Termination / Commencement of Employment Spouse Significant Change in Health Coverage of Employee or Spouse
 Other Please Explain: _____ **Effective Date of Change:** / /

4 Termination Request

Termination Date: / / Benefit Termination Date: / / Reason for Request: _____ **I will Participate in the Section 125 Cafeteria Plan:**
 Yes No (Pre-Tax Benefits)

5 Covered Family Information

If adding/changing coverage for spouse or children, you must complete all information requested. Use another copy of this form for additional children and/or beneficiaries.

SPOUSE: _____ Date of Birth: / / SSN: - - Male Female
 CHILD: _____ Date of Birth: / / SSN: - - Male Female
 CHILD: _____ Date of Birth: / / SSN: - - Male Female
 CHILD: _____ Date of Birth: / / SSN: - - Male Female

Primary Beneficiary: _____
 Relationship: _____
 Contingent Beneficiary: _____
 Relationship: _____

6 Benefit Election/Changes

TRS/BCBS MEDICAL: Pre-Tax / Requires Application Waive All Medical
 TRS Plan 1 TRS HD TRS Plan 2 TRS Plan 3 1st Care S&W
 Employee Only Employee + Spouse Employee + Child(ren) Employee + Family

If you would like more information regarding your benefit options please complete the information below.
 Daytime Call Email

BASIC LIFE: Post-Tax
 Employee Only Coverage: \$10,000

METLIFE DENTAL: Pre-Tax
 Employee Only \$23.29
 Employee + Spouse \$47.73
 Employee + Child(ren) \$62.72
 Employee + Family \$87.59
 Waive All MetLife Dental

SPECTERA VISION: Pre-Tax
 Employee Only \$7.55
 Employee + Spouse \$15.72
 Employee + Child(ren) \$16.48
 Employee + Family \$20.95
 Waive All Spectera Vision

UNUM DISABILITY: Post-Tax Only
 Circle plan option.
Disability Plan A Disability Plan B
 Monthly Benefit: \$ _____
 Monthly Premium: \$ _____
 Waive All Disability

APL CANCER: Pre-Tax / Required Application
Option 1 Option 2/ICU Option 3 Option 4/ICU
 Individual \$13.90 \$17.55 \$26.20 \$29.85
 Single Parent \$20.50 \$25.30 \$36.30 \$41.10
 Family \$26.10 \$33.95 \$46.40 \$54.25
 Waive All APL Cancer

TX LIFE: Post-Tax Required Application
 Monthly Premium: \$ _____
 Waive All Tx Life

UNUM VOLUNTARY LIFE: Post-Tax Waive All Voluntary Life
 Employee \$ _____ Child(ren) Coverage \$5,000
 Monthly Premium \$ _____ Monthly Premium: \$.80
 Spouse \$ _____ Child(ren) Coverage \$10,000
 Monthly Premium \$ _____ Monthly Premium: \$ 1.60

APL ACCIDENT: Pre-Tax
 Waive All Accident
Unit 1 Unit 2
 Individual \$10.80 \$17.10
 Single Parent \$21.20 \$34.90
 Insured + Spouse \$19.40 \$29.80
 Family \$29.80 \$47.60

Unum Critical Illness: Pre-Tax
 Employee Coverage Amount: _____
 Spouse Coverage Amount: _____
 Waive All Unum Critical Illness

UNUM AD&D: Post-Tax
 Employee Monthly Premium: \$ _____
 Spouse Monthly Premium: \$ _____
 Child(ren) Monthly Premium: \$ _____

REIMBURSEMENT ACCOUNTS: Pre-Tax
 Annual Medical: \$ _____
 Annual Dependent Care: \$ _____
 Waive All Reimbursement

I understand that I have verified the benefit selections I have made and authorize any payroll deductions required for those selections. I also understand that any qualifying event change will not be made without proper documentation.

Employee Signature X _____ Date: / / Administrator Signature X _____ Date: / /