POLK COUNTY SCHOOL BOARD CHANGE OF STATUS FORM

FOR OFFICE USE ONLY

ENTERED BY: ________________

DATE ENTERED: ________________

CHECKED BY: ________________

DATE CHECKED: ________________

EFFECTIVE DATE: ________________

Important Information about IRS Permitted Election Changes – *Please read carefully.*

Generally, coverage elections (plan and tier selections) are irrevocable for the payroll reduction and coverage period and changes cannot be made until the next annual open enrollment period. The IRS only permits changes to coverage if certain events occur. In addition, the changes to coverage must be consistent with the change event. Changes may be made within **30 days** of the IRS permitted election change. Allowable IRS permitted election changes, along with a brief description can be found on the back of this enrollment form.

In addition to this completed enrollment form, additional documentation is required for changes to current coverage. It is solely the responsibility of the employee to provide documentation showing proof of IRS permitted election change such as marriage, divorce, birth/adoption, death, court orders, etc. **Forms submitted without the additional required documentation <u>will not</u> be processed.**

EMPLOYEE INFORMATION

Last Name: ____________________ First Name: ____________________ MI: _____

Work Location: ________________ SAP #: ________________

REASON FOR REQUESTED IRS PERMITTED ELECTION CHANGE

Please select the IRS Permitted Election Change that applies to your request.

☐ Marriage ☐ Birth/Adoption ☐ Death ☐ Overage Dependent ☐ Medicare/Medicaid ☐ Divorce

☐ Loss of Other Coverage ☐ Gain of Other Coverage ☐ Legal Guardianship ☐ Other: (Please explain) ________________

Effective Date of Requested Change: ________________

HEALTH INSURANCE

You may elect to cover your eligible dependent(s). **A premium is required for all dependent coverage.** Please refer to your Open Enrollment materials for premium information.

☐ Employee Only ☐ Employee & Dependents ☐ **Waive the PCSB Health Plan**

DENTAL INSURANCE

Please select the dental insurance plan you wish to enroll in. You may elect to cover your eligible dependent(s). Please refer to your Open Enrollment materials for premium information. *A plan is only to be selected if you currently do not participate in a dental plan which is already in effect.*

☐ Low Option ☐ Middle Option ☐ High Option ☐ **Cancel All Dental Coverage**

VISION INSURANCE

You may elect to cover your eligible dependent(s). Please refer to your Open Enrollment materials for premium information.

☐ **Elect Coverage** ☐ **Cancel All Vision Coverage**

DEPENDENT INSURANCE INFORMATION

Relationship to employee	Dependent Name	DOB	M/F	Social Security # (REQUIRED)	Health	Dental	Vision	Dependent Life
					☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove
					☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove
					☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove
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					☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove	☐ Enroll ☐ Remove

MISCELLANEOUS BENEFITS

The following benefits are paid for on a post-tax basis as a result you can drop coverage with these plans, should you choose to do so. However, if you do drop coverage in one of the following insurance plans, you will not be eligible to enter the plan again until the next open enrollment period.

☐ Standard Term Life (formerly Trans America) ☐ AIG Universal Life **Effective Date of Cancellation:** _____

ADDITIONAL TERM LIFE INSURANCE

Certain qualifying events may allow a change to your Additional Term Life Insurance coverage. If you wish to make a change please make your selection. *Medical underwriting requirements may apply.*

☐ 1x's Salary ☐ 2 x's Salary ☐ 3 x's Salary ☐ 4x's Salary ☐ 5x's Salary

FLEXIBLE SPENDING ACCOUNT

Flexible Spending Account (FSA) elections must be made for every Plan Year – deductions do NOT automatically continue each year.

Please enter the total amount(s) you wish to contribute for this plan year: **MEDICAL: $**_____ **CHILDCARE: $**_____

Signature: This form MUST be signed. The information that is provided on this application is accurate and complete. I understand and agree that any incorrect statements made by me on this application may invalidate my and/or my dependents' coverage. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree. I understand that coverage will become effective on the date specified by the Insured after the application has been approved by the Insurer and after the first full premium has been paid. By signing this enrollment form I hereby certify that all the information provided is true and correct.

Authorization to obtain or release medical information: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or confirmation pertaining to medical history or services rendered to us for any administrative purposes, including evaluation of an application or claim, and for any analytical or research purposes.

Payroll deduction authorization: I authorize my employer to reduce my salary in accordance with the benefits I have selected. I understand my selections cannot be changed unless I have a qualifying event as defined by the IRS Section 125 Code and request such changes within 30 calendar days of the qualifying event.

By signing this form, I acknowledge that this is my responsibility to provide the PCSB Risk Management Social Security Number Collection Policy to all and dependents on file. *The full written policy is available on the Risk Management & Insurance page of the Polk County School Board website at:* *www.polk-fl.net/staff/employeeinfo/riskmanagement*

Employee Signature: _____ **Date:** _____

INFORMATION ABOUT IRS PERMITTED ELECTION CHANGES

The IRS only permits changes to coverage if certain events occur. In addition, the changes to coverage must be consistent with the change event. This list is only intended to provide a brief summary of the IRS regulations. It is not intended to substitute for actual laws. In an event of any discrepancy between this summary and the laws, regulations and/or plan provisions then the applicable law shall control.

The IRS permitted election changes, along with a brief description of each are as follows:

Legal Marital Status	Events that change an employee's legal marital status, including marriage, divorce or death of spouse.
Number of Dependents	Events that change the number of dependents, including birth, adoption or death of dependent.
Employment Status	Termination or commencement of employment by an employee or his/her spouse or dependent.
Unpaid Leave	Events such as unpaid FMLA leave.
Ineligible Dependent	Events that cause an employee's dependent to satisfy or cease to satisfy requirement for coverage under the plan(s).
Judgment/Court Order	Events such as when a court order, judgment or decree is issued, including a Qualified Medical Child Support Order (QMCSO) requiring coverage for a dependent.
Medicare/Medicaid/CHIP	Events in which an employee, spouse or dependent becomes entitled to Medicare, Medicaid or CHIP.
Significant Coverage Change	Events in which coverage provided through your spouse's or your dependent's employer's plan has a significant change in cost or coverage.
Loss of Other Coverage	Events in which you/your dependent's lose coverage provided by another group plan.

REQUIRED DOCUMENTATION FOR IRS PERMITTED CHANGES

In addition to this completed enrollment form additional documentation is required for changes to current coverage. Legal documentation of marriages, divorces, adoptions, births, deaths, court orders, etc., must be attached to this completed enrollment form. Forms submitted without the required documentation will not be processed.

Please return the completed form and supporting documentation to:

Risk Management Department – District Office, Route E
OR
PCSB, PO Box 391, Bartow, FL 33831
ATTENTION: Risk Management