



POLK COUNTY SCHOOL BOARD CHANGE OF STATUS FORM

FOR OFFICE USE ONLY

SAP NUMBER: _____

ENTERED BY: _____

DATE ENTERED: _____

CHECKED BY: _____

DATE CHECKED: _____

EFFECTIVE DATE: _____

SECTION A: EMPLOYEE INFORMATION

Last Name: _____ First Name: _____ Mi: _____

Social Security Number: _____ SAP#: _____

Work Location: _____ Requested Effective Date: _____

SECTION B: 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 the actual laws. In an event of any discrepancy between this brief 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 listed below. **Please circle the IRS permitted election change that applies to your request:**

Legal Marital Status	Events that change an employee's legal marital status, including marriage, divorce or death of a spouse.
Number of Dependents	Events that change the number of dependents, including birth, adoption, or death of a 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 a 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, 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.

SECTION C: PLAN AND TIER OPTIONS

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/Orientation materials for insurance premium details.

IMPORTANT NOTE: If you and your spouse are both employees of the PCSB, you may elect couple coverage at no cost. Please see your Open Enrollment Guide for more information on this new benefit.

My spouse & I are both benefits eligible PCSB Employees:

Please enroll my spouse as a dependent on my coverage. Spouse's SAP# _____ (required)
Spouse signature _____ (required) Date _____

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/Orientation materials for insurance premium details. A plan is only to be selected if you do not currently participate in a dental plan. If you do, your dependent(s) will be added to the plan which is already in effect.

Dental Plan Election: Low Option Middle Option High Option

Waive the Dental Plan:

VISION INSURANCE: You may elect to cover your eligible dependent(s). Please refer to your Open Enrollment/Orientation materials for insurance premium details. Enroll is only to be selected if you do not currently participate in the vision plan. If you do, your dependent(s) will be added to the plan which is already in effect.

Enroll in the Vision Plan:

Waive the Vision Plan

Notice of Enrollment Rights- Please read carefully.

I understand that if I and/or my dependents, if any, decline coverage and desire to participate at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents, including my spouse, because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth or adoption, I may be able to enroll my dependents and myself provided that I request enrollment within 31 days after such event.

It is solely the responsibility of the employee to provide documentation showing proof of eligibility for dependents they request to enroll in all Board sponsored group plans. Please provide the following documentation along with this enrollment form:

- Spouse – Marriage License
- Child – Birth Certificate, Adoption Papers or Court Order establishing Legal Guardianship

Dependent Insurance Coverage:

Relationship	Dependent Name	Date of Birth	M /F	Social Security Number (REQUIRED)	Medical	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
					Enroll Remove	Enroll Remove	Enroll Remove	Enroll Remove

SECTION D: 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 TransAmerica)

AIG Universal Life

EFFECTIVE DATE OF CANCELLATION: _____

SECTION E: FLEXIBLE SPENDING ACCOUNT

Please remember deduction amounts requested for the current Plan Year can only be used for the current Plan Year. Flexible Spending Account (FSA) elections must be made for every Plan Year- deductions do NOT automatically continue each year. Please refer to your Open Enrollment/Orientation materials for additional information including limitations and exclusions.

Annual maximum contributions for Medical FSA: \$5,000 Annual minimum contributions for Medical FSA: \$300

Medical: Please enter the amount you wish to contribute for the Plan Year: \$_____

Maximum contribution to Child Care FSA: \$5,000 is married filing jointly \$2,500 if married filing separately

Child Care: Please enter the amount you wish to contribute for the Plan Year: \$_____

SECTION F: AUTHORIZATIONS, NOTICES AND SIGNATURE

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 Insurer 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. I also understand that the health plan may contain a provision, which excludes coverage for pre-existing conditions.

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 it is my responsibility to provide the PCSB Risk Management Social Security Number Collection Policy to all beneficiaries and dependents on file. *The full written policy is available on the Risk Management & Insurance page of the Polk County School Board Website at: <http://www.polk-fl.net/staff/employeeinfo/riskmanagement/default.htm>*

Employee Signature: _____ Date: _____

Please return completed forms to Employee Benefits
by Courier: Employee Benefits, District Office, Route E
or
by mail at The School Board of Polk County
Attn: Employee Benefits
P.O. Box 391
Bartow, FL 33831