CBEBC/DIVISION NAME:______________________________ 2012-2013 Election Form

Please print clearly and copy, scan, and email to Jessica Thierry at jessicat@fbsbenefits.com or fax @ (469)385-4640

New Hire Enrollment ☐ Qualifying Event ☐ Termination ☐ Information Update ☐

1.Employee Information

**All employee information is required for enrollment*

Legal Name		Address	
Date of Birth		City/State/Zip	
Social Security Number		Home Phone	
Gender		Email	

2. Employment Information

**All employment information is required for enrollment*

Date of Hire		Hours Per Week	
Annual Salary		Effective Date	
Pay Frequency			

3. Qualifying Event Change

**Please attach proof and documentation (marriage certificate, letter of credible coverage, etc.)*

Qualifying Event Type	
Effective Date	

4. Termination Request

Termination Date	
Benefit Term. Date	

5. Section 125 Plan Participation

(Pre-Tax Benefits)

Yes	
No	

6. Dependent Information

Spouse		Child	
Date of Birth		Date of Birth	
Social Security Number		Social Security Number	
Gender		Gender	
Child		Child	
Date of Birth		Date of Birth	
Social Security Number		Social Security Number	
Gender		Gender	

Benefit Enrollment/Changes

First Name: Last Name:

*Basic Life		TRS Medical Coverage and Medlink		ID Watchdog ID Theft Protection		
Employee Only Coverage	☐	**Please see your Benefit Administrator to Elect Medical Coverage		Individual	$7.95	☐
		MedLink (Helps to offset out of pocket health expenses)		Family	$14.95	☐
Designate Beneficiaries Below		Plan/Premium:	*Waive MedLink* ☐	*Waive ID Theft*		☐

*UNUM Voluntary Life				Cigna Low Option Dental			Cigna High Option Dental		
Employee Coverage	$	Monthly Premium	$	Employee Only	$13.82	☐	Employee Only	$24.10	☐
Spouse Coverage	$	Monthly Premium	$	Employee+Spouse	$27.63	☐	Employee+Spouse	$46.33	☐
Child(ren) Coverage	$	Monthly Premium	$	Employee+Children	$30.36	☐	Employee+Children	$47.61	☐
		Waive Vol. Life	☐	Employee+Family	$44.17	☐	Employee+Family	$67.16	☐
Designate Beneficiaries Below				*Waive Low Dental*		☐	*Waive High Dental*		☐

Superior Vision			*UNUM Voluntary AD&D		UNUM Educator Disability Plan A		APL Accident		
Employee Only	$7.40	☐	Employee Premium	$	Elimination Period		Employee Only	$10.80	☐
Employee+Spouse	$14.70	☐	Family Premium	$	Monthly Benefit	$	Employee+Spouse	$19.40	☐
Employee+Children	$14.38	☐	*Waive AD&D*	☐	Monthly Premium	$	Employee+Children	$21.20	☐
Employee+Family	$21.90	☐			*Waive Disability*	☐	Employee+Family	$29.80	☐
Waive Vision		☐	*Designate Beneficiaries Below*				*Waive Accident*		☐

APL Cancer Low Option			APL Cancer Low Option w/ICU			APL Cancer High Option			APL Cancer High Option w/ICU		
Employee Only	$13.80	☐	Employee Only	$17.10	☐	Employee Only	$29.90	☐	Employee Only	$33.20	☐
Employee+Children	$19.10	☐	Employee+Children	$23.60	☐	Employee+Children	$40.90	☐	Employee+Children	$45.40	☐
Employee+Family	$24.30	☐	Employee+Family	$31.20	☐	Employee+Family	$51.90	☐	Employee+Family	$58.80	☐
Waive Cancer Option		☐	*Waive Cancer Option*		☐	*Waive Cancer Option*		☐	*Waive Cancer Option*		☐

Reimbursement Accounts		Flexible Spending Debit Card		*PRIMARY BENEFICIARIES		*CONTINGENT BENEFICIARIES	
Medical Reimbursement		**You must elect Medical		Name		Name	
Annual Amount	$	Reimbursement amount. Flex		Relationship		Relationship	
Waive Medical Reimburs.	☐	card is free.		Percentage		Percentage	
Dependent Care Reimbursement		Flex Card	☐	Name		Name	
Annual Amount	$			Relationship		Relationship	
Waive Dependent Care	☐			Percentage		Percentage	

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 ____________________ Administrator Signature ____________________

Date __________ Date __________