

# SPRING BRANCH ISD Pre-Enrollment Worksheet 2009-2010

Information regarding the various benefits offered by SBISD can be found on the District's website:

<http://www.springbranchisd.com/person/benefits/benefits.htm>

**Please review this page and page two**

## **I. EMPLOYEE INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Social Security No: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **II. DEPENDENT INFORMATION – list all eligible dependents to be covered \*\*Socials are required**

1). Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security No: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Relationship: \_\_\_\_\_

2). Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security No: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Relationship: \_\_\_\_\_

3). Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security No: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Relationship: \_\_\_\_\_

4). Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security No: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Relationship: \_\_\_\_\_

## **III. MEDICAL PLAN TRS-ActiveCare BlueCross BlueShield 1-866-355-5999**

*I elect the following plan:*

\_\_\_\_\_ ActiveCare 1-HD \_\_\_\_\_ ActiveCare 1 \_\_\_\_\_ ActiveCare 2 \_\_\_\_\_ ActiveCare 3

*I elect the following coverage for myself and/or my family:*

\_\_\_\_\_ Employee Only \_\_\_\_\_ Employee/Spouse \_\_\_\_\_ Employee/Children

\_\_\_\_\_ Employee/Family \_\_\_\_\_ Employee/ Family Both SBISD

\_\_\_\_\_ I elect to waive medical coverage (Must Decline Online)

## **IV. DENTAL DHMO – Aetna**

**1-877-238-6200**

### **DENTAL INDEMNITY - Aetna**

**1-877-238-6200**

*I elect the following plan:*

*For DHMO plans (provide primary care dentist number) \_\_\_\_\_*

*Must call Aetna to assign a primary dentist*

\_\_\_\_\_ DHMO\* \_\_\_\_\_ Indemnity Plan

\_\_\_\_\_ Employee Only \_\_\_\_\_ Employee/Spouse \_\_\_\_\_ Employee/Children \_\_\_\_\_ Employee/Family

\_\_\_\_\_ I elect to waive dental coverage.

## **V. VISION PLAN – United Healthcare Vision (Formerly Spectera Vision) 1-800-638-3120**

*I elect the following coverage for myself and/or my family:*

\_\_\_\_\_ Employee Only \_\_\_\_\_ Employee/Spouse \_\_\_\_\_ Employee/Children \_\_\_\_\_ Employee/Family

\_\_\_\_\_ I elect to waive vision coverage.

**VI. SUPPLEMENTAL LIFE – The Standard Life Insurance Company 713-251-2459**

---

*I elect the following coverage:*

Supplemental Life & Accident Insurance      Benefit Amount: \$ \_\_\_\_\_  
 Dependent Life & Accident Insurance

I elect to waive the following supplemental life insurance coverage(s):  
 Supplemental Life & Accident       Dependent Life & Accident

**VII. DISABILITY INCOME INSURANCE – Unum 713-251-2459**

---

*I elect the following coverage for myself:*

**Plan B-Short Term Disability**      \$ \_\_\_\_\_ Monthly Benefit

14 day     30 day     90 day     180 day

I elect to waive Plan B(Short Term Disability) coverage.

**Plan A-Short and Long Term Disability**      \$ \_\_\_\_\_ Monthly Benefit

14 day     30 day     90 day     180 day

I elect to waive Plan A(Short and Long Term Disability) coverage.

**VIII. CANCER & Specified Disease Insurance – Allstate/ American Heritage Life 713-251-2459**

---

*I elect the following coverage:*

Employee Only       Employee/Family  
 I elect to waive the Cancer plan.

**IX. LEGAL SERVICES – Pre-Paid Legal Service 713-251-2459**

---

I elect to participate in Pre-Paid Legal plan.  
 I elect to waive the Pre-Paid Legal plan.

**X. PRE-TAX ELECTION – Cafeteria Plan**

---

I elect to have eligible insurance premiums deducted **before** taxes.  
 I elect to have eligible insurance premiums deducted **after** taxes.  
*(Unum Disability, PrePaid Legal, Hospital Indemnity and Long Term Care premiums are always taken after-tax).*

**XI. HEALTH and DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS- Boon-Chapman  
1-800-252-9653 (Option 6) Fax: 1-512-459-1552 www.myrsc.com**

---

*I elect to participate in the following flexible reimbursement accounts:*

Health Care Reimbursement      Annual Election Amount: \$ \_\_\_\_\_ (\$3,000 maximum)

Dependent Care Reimbursement      Annual Election Amount: \$ \_\_\_\_\_ (\$5,000 maximum)

The annual year to date contribution amount is deducted over 16 checks(10-01-2009 to 05-16-2010).

I elect to waive participation in the flexible reimbursement accounts.

**XII. AUTHORIZATION / SIGNATURE**

---

I understand that my benefit elections cannot be changed until the next annual open enrollment period unless I have a change in family status as defined by federal law. Additionally, I authorize SBISD to deduct insurance premiums from my paycheck.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date