| OFFICE USE ONLY: | EE# | Event Date: | Effective Date: | BW | M |
|---|---|---|---|---|---|

# GARLAND ISD BENEFITS CHANGE FORM

**REASON FOR CHANGE:**

Note: Change must be made within 31 days of qualifying event. Documentation required. See EBC for details.

☐ Birth or Adoption ☒ Marriage ☐ Loss of Other Group Coverage ☐ Death of Dependent
☐ Medical Support Order ☐ Divorce ☐ Obtained Other Coverage ☐ Other _____

**EMPLOYEE INFORMATION**

Social Security #: _____ Name: Last, First Middle (Last, First, Middle)

**COVERAGE CHANGES**

**Dental & Vision Plans** - make NEW coverage election below, then indicate dependent information in box:

| | | | | | |
|---|---|---|---|---|---|
| Dental HMO | ☒ Cancel | ☐ Employee Only | ☐ Employee/Child(ren) | ☐ Employee/Spouse | ☐ Employee/Family |
| Dental PPO | ☒ Cancel | ☐ Employee Only | ☐ Employee/Child(ren) | ☐ Employee/Spouse | ☐ Employee/Family |
| Vision | ☒ Cancel | ☐ Employee Only | ☐ Employee/Child(ren) | ☐ Employee/Spouse | ☐ Employee/Family |

DEPENDENT INFORMATION (for dental and vision coverage changes only)

| Add | Drop | Name (last, first, middle) | Social Security # | Date of Birth | Gender | Relationship |
|---|---|---|---|---|---|---|
| | ✔ | | | | Male | |
| | ✔ | | | | Female | |
| | ✔ | | | | Female | |
| | ✔ | | | | Female | |

**Flexible Spending Accounts (FSA's)**

Medical FSA: $ _____ (per plan year) Dependent Care FSA: $ _____ (per plan year)

**AUTHORIZATION**

I certify that the benefit changes requested above meet Section 125 Qualified Family Status Change requirements. I understand that form(s) and documentation must be submitted to the Garland ISD Benefits Department within 31 days of the qualifying event. I authorize the necessary payroll deductions for my change(s). Additional deductions from or adjustments to my next paycheck may be required if a pay period has been missed.

**Signature:** _____ **Date:** _____