2024 Benefit Change Form – Brevard Public Schools

IMPORTANT INFORMATION:

- Change requests must be received by the Employee Benefits Office within 30 days of the qualifying event and include all supporting documentation. Documents may be uploaded to your secure document center in your *Employee Benefits Portal* at bps.primebenefits.io. Select the *Manage Document Uploads* link on your dashboard. Should you need assistance, call (321) 633-1000, Ext. 11216.
- If you are married to another benefit-eligible BPS employee, you each may elect dental and vision coverage on one other, but may not elect medical, life or AD&D coverage on each other.
- A benefit-eligible BPS employee may enroll another benefit-eligible employee who is their child (up to age 26) for all coverage.
- If enrolling in medical coverage, including for a spouse, you must also complete a **Medical Plan Affidavit** regarding:
  - ***Tobacco use*** - a $50/month *tobacco-use surcharge* (post tax) may apply
  - ***Your Spouse's employment/insurance status*** - a $250/month (post tax) *spousal surcharge* may apply
- To cover a ***dependent age 26-30*** (non-disabled), you must also complete an **Over-age Dependent 26-30 (Non-disabled) Affidavit**.
  Medical – If eligible for coverage, an Over-age dependent premium of $358.88/month (post-tax) will apply.
  Dental and Vision – If eligible for coverage, your entire premium deduction becomes *post*-tax.
- You may update your life insurance beneficiaries 24/7 in your *Employee Benefits Portal* at bps.primebenefits.io.

- **Employee Name:** _____ **Employee ID #:** _____ **Site #:** _____
- **Effective Date:** _____ **(Leave blank. For Employee Benefits (for office use only).**

Reason for Request (check one):

☐ Qualifying Event (explain): _____

☐ First Day of Unpaid Leave ☐ Return from Unpaid Leave ☐ Former Retiree ☐ Job Share ☐ Overage Dependent

Premiums listed on this form are MONTHLY amounts.
To calculate your per-pay cost, multiply the premium cost shown below by 12, then divide by your pay frequency.

MEDICAL

☐ Cancel ☐ Change ☐ No Change

Pre-tax

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Silver Plan	☐ $110.53	☐ $523.77	☐ $307.28	☐ $641.33
Gold Plan	☐ $149.26	☐ $606.43	☐ $358.31	☐ $742.19

A **Medical Plan Affidavit** must be completed by the employee if enrolling themself/spouse in medical coverage.

A ***Spousal Surcharge*** of $250 monthly (post-tax) may apply. A ***Tobacco Use Surcharge*** of $50 monthly (post-tax) may apply.

An ***Over-age Dependent Surcharge*** of $358.88 monthly (post-tax) will apply for each dependent child age 26-30 enrolled in medical coverage.

DENTAL

☐ Cancel ☐ Change ☐ No Change

Pre-tax

	Employee Only	Employee + One	Employee + 2 or More
DHMO Low (HD215)	☐ $6.39	☐ $12.65	☐ $22.48
DHMO High (HS210)	☐ $10.48	☐ $20.74	☐ $36.88
PPO Low - Traditional Preferred	☐ $23.82	☐ $48.17	☐ $71.25
PPO High – Traditional Preferred	☐ $30.34	☐ $61.24	☐ $90.44

Provider Facility #: _____
Provider Facility #: _____

VISION

☐ Cancel ☐ Change ☐ No Change

Pre-tax

	Employee Only	Employee + One	Employee + 2 or More
Humana – Basic	☐ $3.92	☐ $9.75	☐ $16.72
Humana – Enhanced	☐ $5.91	☐ $14.69	☐ $25.19

BASIC EMPLOYEE LIFE INSURANCE

☐ Cancel ☐ No Change

Post-tax

Equals one times annual pay. No cost to actively-working employee; premiums are paid by School Board.
Cancellation of coverage is only allowed at the start of an unpaid leave.

ADDITIONAL EMPLOYEE LIFE INSURANCE

☐ Cancel ☐ Change ☐ No Change

Post-tax

Changes only allowed for marriage, birth, divorce or death. You may elect new coverage at 1 x pay or increase existing coverage by 1 x pay. Can cancel, but not increase at the start of an unpaid leave.

☐ 1 x Pay ☐ 2 x Pay ☐ 3 x Pay ☐ 4 x Pay

DEPENDENT LIFE INSURANCE ☐ Cancel ☐ Change ☐ No Change

Post-tax

Changes only allowed for marriage and birth, and death. Can cancel, but not increase at the start of an unpaid leave.

Marriage: may elect up to the maximum coverage for spouse, not subject to evidence of insurability.

Birth: may enroll spouse at minimum or increase 1 x pay, not subject to evidence of insurability, as long as not previously declined.

Death: remove deceased from coverage

☐ $4.12 - Spouse $5,000; and each eligible child $2,500
☐ $4.47 - Spouse $5,000; and each eligible child $5,000
☐ $7.99 - Spouse $10,000; and each eligible child $2,500
☐ $8.33 - Spouse $10,000; and each eligible child $5,000
☐ $17.48 - Spouse $25,000; and each eligible child $2,500
☐ $17.82 - Spouse $25,000; and each eligible child $5,000

ACCIDENTAL DEATH & DISMEMBERMENT ☐ Cancel ☐ Change ☐ No Change

Post-tax

Select tier: ☐ Employee Only ☐ Employee + Family

Select coverage amount: ☐ 1 x Pay ☐ 2 x Pay ☐ 3 x Pay ☐ 4 x Pay

SHORT-TERM DISABILITY ☐ Cancel ☐ No Change

Post-tax

Application for coverage is only allowed during open enrollment. If coverage is canceled and later applied for during open enrollment, the insurance carrier will require evidence of insurability and coverage could be denied.

LONG-TERM DISABILITY ☐ Cancel ☐ No Change

Post-tax

Application for coverage is only allowed during open enrollment. If coverage is canceled and later applied for during open enrollment, the insurance carrier will require evidence of insurability and coverage could be denied.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT ☐ Cancel ☐ Change ☐ No Change

Pre-tax

Enter the amount you want to contribute PER PAYCHECK: $_____ (Maximum annual contribution is $3,200)

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT ☐ Cancel ☐ Change ☐ No Change

Pre-tax

Enter the amount you want to contribute PER PAYCHECK: $_____ (Maximum annual contribution is $5,000)

CRITICAL ILLNESS ☐ Cancel ☐ No Change

Post-tax

Application for coverage is only allowed during open enrollment.

HOSPITAL INDEMNITY PLAN ☐ Cancel ☐ No Change

Post-tax

Application for coverage is only allowed during open enrollment.

ACCIDENT PLAN ☐ Cancel ☐ No Change

Post-tax

Application for coverage is only allowed during open enrollment.

DEPENDENTS TO BE INSURED - Complete for each dependent you are adding to coverage

Dependent Legal Name	Social Security Number	Date of Birth	Relationship	Medical	Dental	Vision	AD&D	Dep Life	Humana Facility Number

My signature below affirms that all information and statements provided on this form are true to the best of my knowledge.

Employee Signature: _____ **Date:** _____

Florida Statute 817.234 - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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