2022-2023 Plano ISD Employee Benefit Plan
Enrollment Form - 25-49% Part-Time Employee (10-19 hrs/wk)

Employee Name _____ **ID #** _____

1. MEDICAL PLAN OPTIONS

★ Choose Your Medical Plan Effective Date: ○ Employment Start Date (partial month premium is not pro-rated)
○ First of the Month Following Employment Start Date

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family	No Coverage Desired ○
ActiveCare Primary	○ $ 410.00	○ $1,157.00	○ $ 738.00	○ $1,384.00	I hereby waive medical coverage.
ActiveCare HD	○ $ 422.00	○ $1,187.00	○ $ 757.00	○ $1,419.00	
ActiveCare Primary +	○ $ 515.00	○ $1,259.00	○ $ 829.00	○ $1,584.00	
Baylor Scott & White HMO	○ $ 543.35	○ $1,364.92	○ $ 873.57	○ $1,570.98	

PCP selection if choosing either Primary or Primary +: _____

★ If you are the spouse of another PISD employee, or of an employee at another school district that participates in TRS-ActiveCare, please contact the benefits office about the option of splitting the medical plan premium, to see whether or not it would be beneficial for you.

2. FAMILY MEMBERS TO BE COVERED

	Name	Sex	Social Security #	Birthdate
Spouse				
Child				
Child				
Child				
Child				

★ If you are requesting coverage for a disabled child over age 26, you must complete the Dependent Child's Statement of Disability form (available on the Forms page at www.pisd.edu/benefits), and return it along with this form.

3. FLEXIBLE BENEFIT PLAN SELECTIONS

Pre-Tax Premiums ○ Yes ○ No

Allows you to pay medical plan premiums on a pre-tax basis.

AUTHORIZATION

I have been provided enrollment materials and the governing plan documents, and I accept the coverage and limitations of the plans. I understand that enrollment is for the 2022-2023 plan year and cannot be revoked or modified until the next enrollment period (unless I experience a change in status as outlined in the proposed regulations of the Internal Revenue Code, Section 125, and request such change in accordance with the timelines set forth in the governing plan documents). I accept any tax consequences that may result from my selections. I consent to the reduction of my salary and wages by the amount necessary to pay for the benefits I have chosen. I understand that if my pay for a pay period is less than the allocated benefit cost for that pay period (determined after taking into account any required pay reserves and any other legally required or higher priority deductions), the remaining cost shall be paid by me on an after-tax basis in such manner and at such time as is required by Plano ISD, or deducted from any other pay otherwise due to me.

Employee Signature _____ **Date** _____

Benefits Office Use Only **Coverage Effective** _____ TEAMS _____

Pay Group: Monthly FacSrv *FANS* *Transp* *PASAR* *Subs* Adjust Payment Sched ☐