Dolgeville Central School

Benefits Change Form

FORM MUST BE RETURNED TO THE BUSINESS OFFICE 2 WEEKS AFTER DATE OF CHANGE

Please print clearly and complete all necessary section in full. Your benefits enrollment form must be completed even if you are waiving coverage of benefits. Please return the completed form to the Business Office, within 2 weeks after your qualifying event date.

PLEASE CHECK APPROPRIATE BOX: **DATE OF EVENT: _____**

☐New Hire ☐Status Change ☐Marriage ☐Birth/Adoption ☐Divorce

PERSONAL INFORMATION

Last Name:[ ] First Name:[ ] Phone #[ ]

SECTION 1. HEALTH INSURANCE

Please check one:

☐Employee Only ☐Employee, Spouse & Children (Family) ☐Waive Coverage

SECTION 2. DENTAL INSURANCE

Please check one:

☐Employee Only ☐Employee, Spouse & Children (Family) ☐Waive Coverage

SECTION 3. FLEXIBLE SPENDING ACCOUNT ELECTION

Please check one:

☐I elect to participate ☐Waive coverage

Minimum annual contribution of $100 and maximum of $2,500. Election are irrevocable and cannot be changed during the year unless you experience a qualified life event as defined by the IRS that allows you to make a change.

I elect to participate in the FSA and would like to contribute $ _____ annually in 2017-18 school year to be deducted on a per pay period basis based on the number of pay periods remaining in this school year.

Note: The FSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment Period.

SECTION 4. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

☐I elect to participate in the Dependent Care FSA and would like to contribute to $_____ annually in 2017-2018 school year to be deducted on a pay period basis based on the number of pay periods remaining in the 2017-2018 school year.

Minimum annual contribution of $100 and maximum of $5,000. Election are irrevocable and cannot be changed during the year unless you experience a qualified life event as defined by the IRS that allows you to make a change.

Note: The DC FSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment Period.

SECTION 5. LIFE INSURANCE

Life Insurance Beneficiary Designation			
Primary Beneficiary			
Name	**SSN**	**Relationship**	**% of Share**
Contingent Beneficiary			
Name	**SSN**	**Relationship**	**% of Share**

SECTION 6. DEPENDENT ENROLLMENT INFORMATION

COMPLETE ONLY IF YOU ARE ADDING, REMOVING, OR CHANGING A DEPENDENT
Please attach a separate sheet for additional dependents.

Add	Remove	Change	Name	SSN	DOB	Sex	Relation	Medical	Dental
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐

Please provide proof of dependents prior coverage, if applicable (policy #, effective date, cancellation date, etc).

SECTION 7. CHANGE OF ADDRESS

Street: _____

City: _____ State & Zip: _____

SECTION 8. EMPLOYEE APPROVAL

I understand that the above elections are effective for this calendar year and may not be changed during the plan year unless I experience a Qualifying Life Event as defined by the IRS and supply the Business Office with the necessary supporting documentation within 30 days of said event. I agree to abide by the regulations and terms of the plans I have enrolled in according to description of each plan. I authorize the Dolgeville Central School to deduct from my paycheck all appropriate premiums for my elections. I confirm that the information listed above is true and accurate. (Please feel free to retrain a copy for your records).

_____ _____

Employee Signature Date

SECTION 9. BUSINESS OFFICE APPROVAL

Reviewed by:

_____

Date Reviewed:

_____

Type of Change	Old	New	Complete	Updated PR/HR
Position				
Health Insurance				
Dental Insurance				
FSA				
Dependent Daycare				
Salary				

Change of Address:

Update nVision (HR/Payroll): _____

Update Excellus: _____

Update Cigna: _____

Update Retirement: _____