



# NORTH EAST ISD CAFETERIA PLAN ELECTION\CHANGE FORM

<b>Name</b>	<b>Social Security#</b>	
<b>Campus/Location</b>	<b>Monthly</b>	<b>Biweekly</b>

**Please fill out this section if you are electing to participate in the Compensation Reduction Agreement:**

I hereby authorize NEISD to reduce my compensation for each pay period commencing on or after the effective date of this selection by the amount of my share of the group premiums for benefits selected by me.  
 I understand that the amount by which my compensation is reduced may increase or decrease over the period in which this selection is effective to reflect changes in the cost of my coverage. I agree not to deduct or claim these expenses on my individual income tax return.  
 I further understand that my salary reduction election shall remain in effect from year to year until I cancel or modify it. I understand that I may cancel or modify my election to participate only during the annual enrollment period unless I cancel or modify my participation due to, and within 31 days of a change in my family status, as explained in the Cafeteria Plan.  
 I hereby release my employer, its officers, board members, agents, and employees, from any legal liability or obligation for any cause or reason in connection with the Cafeteria Plan, except willful misconduct or gross neglect.

I elect to participate in the NEISD Cafeteria Plan.

I elect not to participate in the NEISD Cafeteria Plan.

**I agree to a salary reduction as indicated below:**

\_\_\_ Medical Care Coverage (Blue Cross & Blue Shield)

\_\_\_ Cancer/Catastrophic Illness Plan (Allstate)

\_\_\_ Dental Coverage (Humana Specialty Benefits)

\_\_\_ Vision Coverage (Humana)

I understand that any pre-tax selections are irrevocable for the benefit year (once I select to participate, I MAY NOT drop the coverage) unless I have a change in family status following the pre-tax guidelines assigned by the Internal Revenue Code, Section 125 and related regulations. Enrollment changes must be made within 31 days of a change in family status.

**Please fill out the section below if you have experienced a change in family status:**

According to the Internal Revenue Code, Section 125, a change or revocation of previous elections under the cafeteria plan cannot be made unless there is a family status change. **Completed Application along with supporting documentation of the event must be received within 31 calendar days of the status change. IMPORTANT: If your 31<sup>st</sup> day falls on a weekend or holiday, your forms must be received in the Risk Mgmt/Employee Benefits Office by the last working day prior to your 31<sup>st</sup> day.**

DATE of Family Status Change	TYPE OF STATUS CHANGE
/ /	Marriage/Divorce
/ /	Birth, Legal Adoption, or Change in Custody of Child - Name:
/ /	Death of Spouse or Child - Name:
/ /	Change or Loss of Employment by Spouse, or Dep - Name:
/ /	Leave of Absence
/ /	Ineligibility of Dependent Child - Name: <span style="float: right;">Reason:</span>
/ /	Change in Eligibility - Medicaid or CHIP (60 days)
/ /	Other (please specify) :

ACTION TO BE TAKEN:	<input type="checkbox"/> SELF	<input type="checkbox"/> ADD SPOUSE	<input type="checkbox"/> CANCEL CHILD	<input type="checkbox"/> FAMILY
TO WHICH PLAN:	<input type="checkbox"/> Medical Plan	<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Flexible Spending Account	
	<input type="checkbox"/> Cancer Plan	<input type="checkbox"/> Vision Plan		

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**OFFICE USE:** Change Effective \_\_\_\_\_ Approval \_\_\_\_\_

Return to: Employee Benefits, NEISD, 8961 Tesoro Drive, Suit 209, San Antonio, TX 78217 FAX 210-804-7014

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