Dallas County Benefits Change Form for Plan Year 2027 – Changes Only

This form must be used to make additions/deletions/changes to employee benefit selections.

Name (Last, First, MI) _____ **Birth Date** _____ **Employee Number:** _____

Address _____ **Home Phone** _____

Dept Name _____ **Date of Hire** _____ **Office Phone** _____

Are any of your dependents a Dallas County employee? Yes ☐ No ☐

Reason(s) for Change

Add/Drop a Dependent Due to a Family Status Change. **(Must be within 31 days of event)**

☐ Marriage ☐ Birth/Adoption/Guardianship ☐ Medical Support Order
☐ Divorce ☐ Dependent Loss/Gain in Coverage
☐ Death
Documentation Attached:

Effective Date: _____

Tier Level Change Yes ☐ No ☐

Health Benefits – List ALL new or terminated eligible dependents that will be carried on your medical, dental, and/or vision benefits

Last Name, First Name and MI	Social Security Number	Date of Birth	Relationship	Married (Y/N)	Sex (Male/Female)

MUST select One Box in each area for Your Choice(s) for Coverage. All amounts are bi-weekly deductions.

Medical

	EE Only	EE + Spouse	EE + Children	EE + Family
Choice Plus w/HSA	$ 15.89	$ 242.92	$ 119.19	$ 346.21
PPO	$ 44.10	$ 330.76	$ 173.09	$ 459.76
No Coverage				

Dental

	EE Only	EE + Spouse	EE + Children	EE + Family
DHMO	$ 5.51	$ 9.39	$ 12.39	$ 15.83
PPO	$ 18.87	$ 34.88	$ 43.37	$ 60.35
No Coverage				

Vision

	EE Only	EE + Spouse	EE + Children	EE + Family
Vision	$ 2.88	$ 5.40	$ 5.75	$ 8.95
No Coverage				

Spouse Optional Life **(Employee must be enrolled in Optional Life Plan)**

☐ $ 10,000 ☐ $ 25,000 ☐ $ 50,000 ☐ $ 75,000 ☐ $ 100,000

Dependent Life

☐	$ 10,000 Spouse +	☐	$ 5,000 Spouse +	☐	No Coverage
$.97	$ 5,000 Children	$.49	$ 2,500 Children		

Flexible Spending Accounts

☐	Health Care Spending Account	$ Min $ 4.62 Max $ 130.76	☐	Dependent Care Spending Account	$ Min $ 4.62 Max $ 192.30

I certify the information I have provided is true and correct and acknowledge that falsification of any information may lead to disciplinary action up to and including termination. I understand the benefit selections made and authorize bi-weekly payroll deductions on a pre-tax basis for these selections. I also understand these selections are effective through the plan year and cannot be changed, unless I have a qualified change in family status, with this qualifying change. I understand I must submit a request for this change to Human Resources by email at Benefits@dallascounty.org or at 500 Elm Street, Suite 4100, Dallas, TX 75202, ***within 31 days of the qualifying event, by completing a*** **"Benefits Enrollment Change Form".**

Employee Signature _____ Date _____ HR _____