MUST BE RETURNED TO CCISD PAYROLL

CALHOUN COUNTY ISD SUBSTITUTE

SCHOOL YEAR 2021/2022

There are two categories of substitutes for the 2021/22 school year.

A **part time** substitute: working up to 14 days per month

A **full time** substitute: available to work every school day per month

I have signed up to substitute for the 2021/22 school year at Calhoun County ISD. I understand that as a part time sub I cannot work more than 14 days per any calendar month. As a full time substitute I understand that if needed I am able to work every school day per month.

Subs are hired on an as needed basis and are not guaranteed any number of days per month.

Please check one item below to denote which type of substitute you are signing up for during the 2021/22 school year.

_____ Part time substitute

_____ Full time substitute

_____ _____

Print Name Date

_____

Signature

Calhoun County ISD

July 15, 2021
Dear CCISD Substitute:

Calhoun County ISD provides health coverage to employees through TRS-ActiveCare. A district substitute is eligible to enroll in TRS-ActiveCare if the district reasonably expects the substitute to work at least 10 hours per week. Hours worked for other school districts are not considered in determining whether a substitute is eligible for benefits through Calhoun County ISD.

Although the district reasonably expects substitutes to work at least 10 hours per week, the district does not guarantee that you will receive 10 hours every week. The district's need for substitutes varies from week to week. In some weeks, you may not receive any assignments. Similarly, the district understands that some weeks you may not be able to accept assignments due to illness or other personal reasons.

If you are a new substitute, you must enroll in or decline medical coverage within 31 days from date of hire. If you are a returning substitute, you must enroll in or decline medical coverage during the annual open enrollment. If you decline coverage, you cannot enroll again until the next plan year unless you experience a special enrollment event.

If you elect to enroll, **you will be responsible for the full premium of $417 for ActiveCare Primary, $429 for ActiveCare HD, or $542 for ActiveCare Primary +.** These are the current premiums for the employee only. You must submit payment for one calendar month with your enrollment form. The premium for subsequent months will be deducted from you pay for the preceding month. If your pay is not sufficient to cover the full premium, you must submit the difference to the district by the 25th day of the month. If the 25th falls on a weekend or a day the district is closed, the payment must be made the preceding business day. If you fail to timely pay the monthly premiums, the district will proceed with the coverage cancellation process. Your coverage may also be canceled if you lose eligibility for TRS-ActiveCare.

You may be removed from the district's substitute roster for poor performance or misconduct. In addition, you may be removed from the substitute roster if:

- you repeatedly turn down assignments, are repeatedly unavailable for calls, or frequently cancel assigned positions.
- you do not timely return a letter of reasonable assurance

A substitute who is enrolled in TRS-ActiveCare and who is then removed from the substitute roster becomes ineligible for health coverage and will be provided notice regarding continuation coverage under COBRA (if eligible). Cancellation due to non-payment is considered a voluntary drop: Therefore you would not be eligible for COBRA.

You have received this letter because we have you set to sub for CCISD the 2021/22 school year.

If you wish to decline coverage please do so on the attached form and return to payroll by August 5, 2021. If you wish to enroll, please contact Cindy Partida at 361-552-9728 in our insurance department by August 5, 2021.

TRS ACTIVECARE

Enrollment Application and Change Form

WellSystems®

ELIGIBILTY:	Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No	(If no to both, you are not eligible for TRS ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ **For New Employee** (check one): ☐Effective on Actively at Work ☐Effective 1st day of month following

Special Enrollment Event Date: __/__/____ ☐Marriage ☐Court Order ☐Birth/Adoption ☐Loss of Coverage ☐Other:

Change Only:
☐ Name
☐Address
☐Plan/Coverage

Decline Coverage:
☐Yes (Complete Section 6)
☐N/A

Effective Date of Change/Cancel
____/____/_____

Cancel Employee
☐Death
☐Loss of Eligibility
☐Retirement/Terminated
☐Non-Payment
☐Other: _____

Cancel Dependent
☐Divorce
☐Death
☐Loss of Eligibility
☐Dropped Coverage
☐Other: _____

For District Use Only
TRS District #
Actively at Work Date:
Effective/Change Date:
Employer Approval: _____
Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:	City:	State:	Zip:
Home Phone Number:	Cell Phone Number:	Email:	
Date of Birth:	Sex: ☐M ☐F	Language: ☐ English ☐Spanish	Ethnicity:

Do you have a disability affecting your ability to communicate or read? ☐Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐Yes Carrier/Plan: ☐No

Is the Employee Covered by Medicare? ☐Yes ☐Part A ☐Part B ☐Part C ☐Part D Effective: ☐No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection: ☐ActiveCare 1-HD ☐ActiveCare Select ☐ActiveCare 2

HMO Selection: ☐FirstCare Health Plans ☐Scott & White Health Plan ☐Allegian Health Plans (formerly Valley Baptist Health Plans)

Coverage Type Selected: ☐Employee Only ☐Employee + Spouse ☐Employee + Child(ren) ☐Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name: First Name: MI:

Street Address: ☐Same as Employee

City: State: Zip: Phone Number:

Sex: ☐M ☐F Date of Birth: Social Security #:

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

CHILD Last Name: First Name: MI:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other

Street Address: ☐Same as Employee

City: State: Zip Code: Phone Number:

Date of Birth: Social Security #: Sex: ☐M ☐F

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

CHILD Last Name: First Name: MI:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other

Street Address: ☐Same as Employee

City: State: Zip Code: Phone Number:

Date of Birth: Social Security #: Sex: ☐M ☐F

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:
☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other		
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D	
CHILD Last Name:	First Name:	MI:
☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other		
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F:
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D	

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 ☐Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	☐Employee	Reason:	☐Other Coverage	☐Other:
Name:		☐Spouse	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, Scott and White Health Plan, and Allegian Insurance Company dba Allegian Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
  - If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)

CALHOUN COUNTY ISD
029901 PERSONNEL POSITIONS:
LETTER OF REASONABLE ASSURANCE

LETTER OF REASONABLE ASSURANCE

TO: **All Non-Contractual and Substitute Employees** DATE: **April 21, 2021**

Thank you for supporting CCISD. Please accept this letter as a means of informing you of ***reasonable assurance of employment when each school term resumes after a school break.*** By virtue of this notice, please understand that you may not be eligible for unemployment compensation benefits drawn on school district wages during any scheduled breaks including, but not limited to, the summer, Christmas, and spring breaks. This assurance is contingent on continued school operations and will not apply in the event of any disruption that is beyond the control of the district (i.e. lack of school funding, natural disasters, court orders, public insurrections, and/or war).

Nothing contained herein implies an employment contract. Your continued employment is on an at-will basis. Employers may terminate at-will employees at any time for any reason or for no reason, except for legally impermissible reasons, and at-will employees are free to resign at any time for any reason or for no reason.

Your service on behalf of the children in the district is appreciated.

Larry W. Nichols, Superintendent of Schools

Kelly Taylor, Assistant Superintendent

Please check the position which is applicable to you.

NON-CONTRACTUAL:
_____ Paraprofessional/ Aide/ Fellow/ Officer
_____ Teacher/ LSSP
_____ Transportation
_____ Food Service
_____ Maintenance/Custodian
_____ Respite Prog.

SUBSTITUTE:
_____ Food Service
_____ Maintenance/Custodian
_____ Respite Prog.
_____ Paraprofessional
_____ Teacher
_____ Transportation

NOTICE: **KEEP ONE COPY/ RETURN SECOND COPY** **DO NOT CUT — RETURN ENTIRE PAGE**

Please complete the following information and return the original letter to the campus main office. Substitutes please return to the Personnel Office, Calhoun Co.ISD, 525 N. Commerce St., Port Lavaca, TX 77979 within 10 days of the employment recommendation.

I would like to retain my status as a CCISD employee. I agree to comply with the rules, regulations, and policies of Calhoun County Independent School District. Failure to sign and return this notice by the date listed will be viewed as a resignation.

Name (Print) _____ Date _____

Signature _____ Employee ID # _____

Address (Street address and P.O. Box) & City Zip Code _____ Telephone Number _____

SUBSTITUTE ONLY: Annual District training is required prior to services. It will be held at the Travis Middle School Science building on July 20, 2021, at 8:30 am. Please visit Calcoisd.org for the sub schedule I will be available to work beginning August 2021.

I will be available to serve as a substitute at all campuses except _____.

CALHOUN COUNTY INDEPENDENT SCHOOL DISTRICT
Payroll Direct Deposit

Your payroll check may be direct deposited to any financial institution.

_____I **DO** choose to participate in payroll direct deposit as indicated below.

_____Please **cancel** my direct deposit as of _____ (date).

_____Please **change** my direct deposit as indicated below.

_____ I **DO NOT** want to participate in direct deposit.

If you wish to have your paycheck direct deposited, **you must provide the following information and attach a voided check from your bank.**

Employee Signature: _____Date:_____

Employee ID Number:_____Campus:_____

Name of Bank: _____

City/Town of Bank: _____

Name your account is listed under: _____

Type of account: checking_____ savings_____

Account number: _____

Bank routing number: _____

Split deposit amount $_____

You can deposit your check in one or two accounts. If you choose to use two accounts, the above information is needed for each account and you must specify the amount to be deposited in the first account, then the remainder of your check will go to the second account. We **must have a voided check or printed form from the bank for each account.**

Questions may be directed to Heather Conde or Sherry Roberts at 552-9728.