



Date Received by Disability and Leaves: \_\_\_\_\_

# BENEFIT BILLING ELECTION

FCPS regulations require that you have the opportunity to continue your benefits while on a leave of absence (LOA). If you want to maintain your benefits while on an LOA, you **must** complete this form and **enclose your first month's payment** via check or money order **no later than 30 days** after the date of your LOA approval letter. Mail the completed form and payment to the full address below:

Fairfax County Public Schools  
Office of Benefit Services-Benefits Processing  
8115 Gatehouse Road  
Falls Church, VA 22042

**If you do not return this completed form and your payment, FCPS will cancel your benefits on the last day of the month for which you have paid.** For example, if your leave is approved April 5 and your benefits are paid through payroll deductions in April, your benefits will end April 30. FCPS will reinstate your benefits upon receipt of your payment within the 30-day period. Benefit premiums are based on your employment contract—either 10, 11, or 12 months (or 20, 22, or 26 weeks). If you have a 10-month (20 weeks) contract, FCPS will not bill you in July and August. If you have an 11-month (22 weeks) contract, FCPS will not bill you in July, although you will continue to have benefits coverage during July and/or August. You will have to reenroll for optional benefits (e.g. medical, dental, flexible spending accounts, personal retirement savings plans (403(b) and 457(b)), long-term care, optional life) when you return to work.

If you have questions about your benefit coverage or reinstatement, contact the Human Resources Client Services Center at 571-423-3000.

**Check the appropriate box(es) for benefits you wish to maintain while on an LOA:**

- Medical Insurance
- Dental Insurance
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Long-Term Disability (LTD)  
(premiums will be waived if you are receiving LTD payments)
- Minnesota Mutual Basic County Life Insurance  
(FCERS members)
- Minnesota Mutual Optional Life Insurance  
(FCERS member)
- VRS Basic Life Insurance  
(VRS and/or ERFC members)
- VRS Optional Life Insurance  
(VRS and/or ERFC members)

If applicable, complete the following: I choose to cancel health coverage for the following dependents. Include dependent's name, date of birth, and check health plan coverage you wish to cancel.

_____	_____	<input type="checkbox"/> Medical Insurance
<i>Name</i>	<i>Date of Birth (month/date/year)</i>	<input type="checkbox"/> Dental Insurance
_____	_____	<input type="checkbox"/> Medical Insurance
<i>Name</i>	<i>Date of Birth (month/date/year)</i>	<input type="checkbox"/> Dental Insurance
_____	_____	<input type="checkbox"/> Medical Insurance
<i>Name</i>	<i>Date of Birth (month/date/year)</i>	<input type="checkbox"/> Dental Insurance

_____	_____
Employee ID Number (see pay stub, upper left corner)	Home Phone Number (include area code)
_____	_____
Name (First, Middle Initial, Last)	Date of Birth (month/date/year)
_____	
Home Address	
_____	
City, State, Zip	
I acknowledge that FCPS will cancel my benefits if I do not pay premiums and contributions by the end of the month.	
_____	
Your Signature	