

## Health Plan Eligibility and Deduction Authorization For Both Spouse Employees

*To be completed by the Office of Benefit Services. Coverage effective date \_\_\_\_\_*

Please **PRINT**

► I (subscriber) request and hereby authorize Fairfax County Public Schools (FCPS) to make the necessary deduction from my pay following the acceptance of my application, and thereafter until otherwise notified, for our health coverage with the following plan(s):

**Check Plan(s):**

- CareFirst (BluePreferred) (PPO)
- CareFirst BlueChoice (POS)
- Kaiser Permanente (HMO)
- Aetna Dental DPPO
- Aetna Dental DMO

**Check Coverage Level:**

- Minifamily (you and spouse)
- Family (you, spouse, and children)

By signing this form and providing a copy of our marriage certificate, we certify that we are married to one another and are employed by FCPS. Should our marriage terminate, one of us leave FCPS employment, or one of us be granted leave of absence without pay, **we will** notify the Office of Benefit Services (OBS) of such change in employment or marital status. Failure to notify OBS does not prohibit FCPS from billing us for additional premiums based on our ineligibility for the contribution.

This benefit becomes effective the first of the month following the effective date of the change or the first day of the plan year if the change is made during open enrollment. **This benefit is not retroactive for employees who fail to request the contribution at the date of initial eligibility.**

► Subscriber	► Spouse
_____ Subscriber's name	_____ Spouse's name
_____ Subscriber's Social Security number* or Employee ID Number	_____ Spouse's Social Security number* or Employee ID Number
_____ Subscriber's occupation and work location	_____ Spouse's occupation and work location
_____ Subscriber's signature	_____ Spouse's signature

► When complete, return this form to the Office of Benefit Services, Department of Human Resources, 8115 Gatehouse Road, Falls Church, VA 22042, or fax to 571-423-5000.

► To be eligible for the Both Spouse rate, the subscriber and spouse must be enrolled in the same FCPS plan with one spouse listed as a dependent of the other (subscriber). You must complete and submit the Medical and or Dental Enrollment forms (HR-120, HR-121) with this form. Forms are available at [www.fcps.edu/DHR/employees/benefits/index.htm](http://www.fcps.edu/DHR/employees/benefits/index.htm), or call the Human Resources Client Services Center at 571-423-3000.

\*Providing your Social Security number (SSN) is optional. Failure to provide it may result in processing delays or errors, but will not result in a denial of benefits. The full text of the FCPS SSN privacy notice can be found at [www.fcps.k12.va.us/DHR/applicants/disclosures.htm](http://www.fcps.k12.va.us/DHR/applicants/disclosures.htm)