Medical & Dental Enrollment and Change Form

Fairfax County PUBLIC SCHOOLS
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Action requested due to: (check one)

☐ Enroll ☐ Cancel coverage ☐ Change plan(s)
☐ Add dependent(s) ☐ Drop dependent(s) ☐ Re-employed retiree
☐ Other (please describe): _____

To ensure your request is processed as quickly as possible, please read the instructions and important information below:

- If enrolling for coverage as a newly hired or newly eligible employee, you must submit your elections **within 30 days of your date of hire/ eligibility** through the Onboarding portal. Coverage will then take effect on the first day of the month following your date of hire/eligibility. If your date of hire/eligibility is the first day of the month, coverage will become effective on that date. If requesting coverage for your spouse or eligible dependent child(ren), make sure you supply the required documents listed on page 4 within your 30-day eligibility window.
- Requesting changes in coverage due to a qualifying event must be submitted **within 30 days of the status change or qualifying event,** with changes in coverage effective the first day of the month after the qualifying event (except for birth or adoption, which take effect on the date of birth or adoption). See page 4 for the list of required documents.
- To speed up processing, complete all applicable pages of this form AND attach any required documents. Call 571-423-3200, option 3, if your documents will not be available within the 30-day period. **Do not hold your form waiting on documentation, as you could miss the enrollment deadline.**

1. Your Information (Please print clearly)

Your Name (Last, First, MI) _____ Date of Birth _____

Your Home Address (street and apt. number) _____ Social Security Number (SSN) or Employee ID Number _____

City, State, Zip Code _____

Home Phone _____ Work Phone _____

Email Address _____

Pay Frequency:

☐ Biweekly ☐ Monthly

--Or Direct Bill--

☐ COBRA ☐ LOA

2. Reason for Submitting Form

☐ New Employee ☐ Divorce ☐ Other (please describe): _____
☐ Marriage ☐ Birth of Child

Date Occurred: _____

3a. Medical Plan Election

I would like to: ☐ **Enroll/change coverage** (Complete Sections 3b and 3c) ☐ **Cancel/decline coverage**

3b. Choose a Medical Plan

☐ Cigna Open Access Plus (includes CVS Caremark pharmacy benefits) ☐ Kaiser Permanente Signature HMO (includes pharmacy benefits)

3c. Select Your Level of Coverage

Coverage for yourself only	**Coverage for yourself + 1 dependent**	**Coverage for yourself and 2+ dependents**
☐ Individual	☐ Employee + 1	☐ Family

4a. Dental Plan Election

I would like to: ☐ **Enroll/change coverage** (Complete Sections 4b and 4c) ☐ **Cancel/decline coverage**

4b. Choose a Dental Plan

☐ Aetna Dental PPO ☐ Aetna Dental DNO
If electing the DNO plan, you MUST contact Aetna Dental to designate a primary care dentist (PCD).

4c. Select Your Level of Coverage

Coverage for yourself only	**Coverage for yourself + 1 dependent**	**Coverage for yourself and 2+ dependents**
☐ Individual	☐ Employee + 1	☐ Family

SSN or EIN ____________________

5. Dependent Enrollment Information

List only the names of those individuals you wish to ADD to coverage. To drop dependents use box 6. Skip to section 7 if no dependents.

Name (Last, First, MI)	**Social Security Number** (see box 9) (Required at time of enrollment, except for newborns)	**Gender, Relationship, and D.O.B.**	**Plans to Enroll In**
Dependent Name	SSN	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental
Dependent Name	SSN	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental
Dependent Name	SSN	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental
Dependent Name	SSN	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental
Dependent Name	SSN	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental

Please note: If your spouse is an FCPS employee eligible for health insurance, you must also complete form **HR-134** to receive the Two Employee Spouse Discount.

6. Remove Dependents

Complete only if YOU, the employee, are retaining coverage and are requesting to remove the dependent(s) listed below from FCPS medical and/or dental coverage.

Name (Last, First, MI)	**Relationship and D.O.B.**	**Remove from**
Dependent Name	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Both Medical & Dental
Dependent Name	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Both Medical & Dental
Dependent Name	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Both Medical & Dental
Dependent Name	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Both Medical & Dental
Dependent Name	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Both Medical & Dental

SSN or EIN _____

7. Acceptance

I hereby apply for or decline coverage on behalf of myself and each eligible dependent. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and Fairfax County Public Schools (FCPS), and applicable FCPS directives.

I understand that I cannot cancel or change this election unless I experience a qualifying change in status or Special Enrollment Right under the Health Insurance Portability & Accountability Act (HIPAA), and that I must notify the Office of Benefit Services in the Department of Financial Services within **30 days** of any change in status which would cause any of my covered dependents to cease to be eligible for benefits under the health or dental plans. If I fail to notify the Office of Benefit Services by filing the appropriate forms, I will be responsible for any claims and/or premiums paid on behalf of any individual who ceased to be eligible for benefits under the policy. It is my responsibility to keep informed of any changes to the plan that might affect my eligibility or my dependent(s) eligibility.

I understand that by completing and signing this enrollment form, I am making a binding election with regard to my benefits and that I am authorizing FCPS to make the necessary reduction in my compensation to pay my share of the cost of coverage, including any retroactive deductions if required. This election will continue in future plan years unless I request an authorized change in my election during the annual open enrollment period. See the FCPS Employee Benefits Handbook for more information.

Employee Name (Last, First, MI): _____

Employee Signature: _____ **Date:** _____

8. Instructions (Submit only pages 1, 2, and 3. Page 4 is for your information only.)

Scan and submit form to:	FCPS StaffConnect
Or fax to:	Office of Benefit Services at 571-423-5000
Or mail to:	Department of Financial Services Office of Benefit Services, Suite 2700 8115 Gatehouse Road Falls Church, VA 22042

Remember to keep a copy of this form for your records. If you fax this form, also keep a copy of your fax machine's transmission report as documentation that we received the form by the deadline. Forms that are received after applicable deadlines cannot be accepted.

9. FCPS Policy Regarding Use of Social Security Numbers for Health Coverage Enrollment

Patient Protection and Affordable Care Act:
Reporting requirements of the Patient Protection and Affordable Care Act require employers to file an annual report with the IRS that includes Social Security numbers (SSN's) for all individuals, including spouses, and dependent children enrolled in employer-sponsored medical plans (IRC Section 6055). You are requested to provide FCPS with the SSN's of all covered dependents to comply with this requirement.

Medicare, Medicaid and SCHIP Extension Act of 2007:
Medicare, Medicaid and SCHIP Extension Act of 2007, 42 U.S.C. 1395y (b) (7) & (8), mandates employers to submit SSN's of all medical plan enrollees who are age 45 and over or are Medicare eligible regardless of age to the Center for Medicare and Medicaid Services.

Questions? Contact the Office of Benefit Services at 571-423-3200 option 3, or submit your questions to FCPS StaffConnect.

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Important Information Regarding Documentation Requirements

All changes in benefit elections must be necessitated by, and consistent with, the change in family status. The change must be acceptable under the IRS regulations which govern pre-tax deductions.

Documents Required When Adding Dependents

The documents listed below must be provided when you are requesting coverage for your spouse/dependents. Copies of these documents can typically be obtained in the locality where the birth or marriage occurred, or via these websites: www.vitalchek.com; www.vitalrec.com. Fees will likely apply. If documentation is not in English, you must submit a certified translation of document(s) prior to supplying it to the Office of Benefit Services. For information on obtaining a copy of your tax return visit www.irs.gov/taxtopics/tc156.html.

Relationship	Documentation Required
Spouse- A person to whom you are legally married	Photocopy of the first page of the employee's IRS Form-1040 for the most recent tax year that includes the employee's filing status, which must be "Married filing jointly" or "Married filing separately" (you may remove all financial information). A photocopy of IRS Form-4868 can be submitted in lieu of the Form-1040 if both employee and spouse are listed. *Note: Not required if married in same year as being added to plan **-AND-** Photocopy of government issued marriage certificate
Adopted Child- An adopted son/daughter of the employee or a child placed for adoption	Photocopy of a Final Adoption Decree or an Interlocutory Decree of Adoption with the presiding judge's signature and seal; **-OR-** Photocopy of the child's birth certificate showing the employee as the adopting parent.
Biological Child/Stepchild- A biological son/ daughter of the employee, or son/daughter of the employee's spouse	Photocopy of birth certificate showing the employee or spouse's name as mother or father; If adding a stepchild, must also provide a photocopy of the employee and spouse's marriage certificate and a copy of your most recent federal tax return documenting marital status.
Child under Legal Guardianship- A child for whom the employee has been appointed legal guardian	Photocopy of the final court order, with the presiding judge's signature and seal, affirming the employee as the child's legal guardian.
Child under Legal Custody- A child for whom the employee has been granted legal custody	Photocopy of the court order of custody with the presiding judge's signature and date, affirming the child's placement in legal custody of the named employee.
Foster Child- Certain eligible foster children	Photocopy of the certified foster care documents with the name of the child and the name of the employee.
Disabled Child- Age 26 or older, who is wholly dependent on the employee for support and maintenance due to a disability that occurred prior to age 26 and who has been certified as disabled by the health/dental plan. No disability certification is required for a child under age 26.	Photocopy of birth certificate showing employee's name as mother or father **-AND-** You must also complete the health/dental plan's disability certification form, available from the FCPS website. Search on keywords "benefits forms".

Additional Documentation Required

Other documents may be required when making changes to your coverage as the result of a qualifying event or status change.

Divorce or Annulment	Copy of first and last page of divorce decree (includes final judgement date and signature). Also required: Former spouse's mailing address. *Note: If receiving the Two Employee Spouse discount, you must also complete the form HR-134.
Change in Employment, Eligibility, or Significant Cost Change- Spouse/dependent's change in employment that affects eligibility for medical and/or dental benefits or significant change in cost	Letter from employer documenting change in status and effective date; open enrollment notice from employer with enrollment and effective dates; documentation from employer showing costs before and after plan change and effective date.
Death of Spouse/Dependent	Copy of death certificate.
Loss of Coverage (other than termination for non-payment of premium)	Attach documentation showing the individuals covered, type of coverage lost (i.e., medical and/or dental coverage), reason coverage was lost, and date coverage ends.
Entitlement to/or loss of Medicare or Medicaid Coverage	Attach letter from Medicare/Medicaid showing date entitled (or lost) eligibility.
COBRA Exhaustion- or other involuntary loss of COBRA coverage	Letter from plan administrator documenting loss/expiration of COBRA coverage and effective date.
Move Outside the Service Area	Address must be updated in Lawson/UConnect.
Dependent Name and/or Gender Identity Change	Photocopy of valid driver's license or DMV identification card, U.S. passport, Social Security card, or birth certificate showing the dependent's name and/or gender.

Note: This is not an exhaustive list. Additional documentation may be required for qualifying events not specified above. Refer to the FCPS Employee Benefits Handbook for more information about qualifying events.