



Optional Employee & Dependent Life Insurance Election and Change Form

(for eligible FCPS employees and retirees covered by the Fairfax County Employees' Retirement System)

Optional Employee & Dependent Life Insurance: *(Coverages are 100% employee / retiree paid.)*

Active Employees: Use this form to elect, change, or cancel Optional Employee Life insurance and/or Dependent Spouse/Child(ren) Life Insurance.

Retirees: Use this form to reduce or cancel Optional Employee Life insurance and/or Dependent Spouse/Child(ren) Life Insurance.

Basic Life Insurance: *(FCPS pays for Basic Life Insurance coverage.)*

This coverage is mandatory and automatic for employees covered by FCERS, and retirees who were eligible to continue coverage into retirement.

For More Information:

Active Employees: <https://www.fcps.edu/careers/salary-and-benefits/insurance-benefits/life-insurance>

Retirees: <https://www.fcps.edu/Life-Insurance-Benefits-for-Retirees>

Beneficiary Designations for Life Insurance: You can review and update your beneficiaries online by accessing your MetLife MyBenefits account or submit your beneficiary designations by mail to MetLife. Go to <https://www.fcps.edu/Updating-or-Changing-Your-Beneficiaries> to learn more.

Section 1: Your Information <i>Please print clearly.</i>			
Your Name (Last, First, Middle)	Date of Birth	Social Security Number or Employee ID Number	
Your Home Address (Street and Apt. Number)	City	State	Zip Code
Home Phone	Work Phone	Work Email Address	
Your Status: <input type="checkbox"/> Employee <input type="checkbox"/> Retiree		Personal Email Address	

Section 2: Why are you submitting this form? <i>Check the appropriate box.</i>
<input type="checkbox"/> I am a new hire, re-hire, or newly eligible for benefits and want to elect optional life and/or dependent life coverage: <i>Indicate your coverage election in section 3 and complete section 4.</i> You must apply for optional life and/or dependent life insurance within 30 days from your date of hire, re-hire, or date of benefits eligibility. Coverage is effective 1 st of the month following receipt of this completed form in the Office of Benefit Services. If you do not apply within 30 days, you must complete a Statement of Health (SOH) form and subject to review and approval by MetLife. You can find the SOH form at https://www.fcps.edu/careers/salary-and-benefits/insurance-benefits/life-insurance .
<input type="checkbox"/> I am reducing and/or canceling my optional life and/or dependent life coverage: <i>Indicate your request to reduce and/or cancel coverage in Section 3 and complete section 4.</i> Coverage changes / cancelations are effective 1 st of the month following the receipt of this completed form in the Office of Benefit Services. FOR RETIREES: Be aware that if you reduce or cancel your life insurance coverage with Fairfax County Public Schools, you will not be able to reinstate such coverage in the future.
<input type="checkbox"/> I am requesting an increase in optional life or dependent life coverage due to the qualifying event below: <i>This is option available only to employees actively at work in a benefits-eligible position. Indicate your new coverage election in Section 3.</i> You may elect / increase optional life and dependent life within 30 days of the following qualifying life events without a Statement of Health (SOH). Otherwise, a SOH is required. The requested change must be consistent with the event. My status change/qualifying event is: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/adoption <input type="checkbox"/> Other (please describe): _____ Date status change/qualifying event occurred: _____

- Please complete second page/reverse side -

Section 3: Coverage Election *Please select.*

Optional Employee Life Insurance – Coverage is paid in full by the employee / retiree.

New or newly eligible employee: *Check the appropriate box.*

Changing or Canceling Coverage: *Check the appropriate box to indicate your updated election.*

- Decline / Cancel Optional Life Insurance
- 1 x Salary Optional Life Insurance coverage
- 2 x Salary Optional Life Insurance coverage

NOTE: If you are requesting an increase in coverage and a Qualifying Event does not apply, you must submit the Statement of Health (SOH) form to MetLife. You can find the SOH form at <https://www.fcps.edu/careers/salary-and-benefits/insurance-benefits/life-insurance>.

Optional Dependent Life Insurance – This is additional coverage for your spouse and/or dependent children. Coverage is paid in full by the employee / retiree. **NOTE:** If your spouse/child is eligible for FCERS coverage, they cannot be covered as a dependent, and no person may be covered as a dependent of more than one employee.

New or newly eligible employee: *Check the appropriate box.*

Changing or Canceling Coverage: *Check the appropriate box to indicate your updated election.*

SPOUSE LIFE INSURANCE

- Decline / Cancel Spouse Life Insurance
- Spouse Life Option 1 – \$10,000, or
- Spouse Life Option 2 – \$20,000

CHILD LIFE INSURANCE (child eligibility – ages 10 days to 26 years, and over age 26 if dependent child 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 FCPS health / dental / life plan)

- Decline / Cancel Child Life Insurance
- Child Life Option 1 – \$5,000 per Child, or
- Child Life Option 2 – \$10,000 per Child

Dependent Enrollment Information -- List the names of those individuals you wish to ADD or REMOVE from coverage:

Dependent's Name (Last, First, MI)	Relationship and Gender	Date of Birth (MM / DD / YYYY)	Requested Enrollment Action
	<input type="checkbox"/> Spouse <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Add Spouse Life <input type="checkbox"/> Remove Spouse Life
	<input type="checkbox"/> Child <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Add Child Life <input type="checkbox"/> Remove Child Life
	<input type="checkbox"/> Child <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Add Child Life <input type="checkbox"/> Remove Child Life
	<input type="checkbox"/> Child <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Add Child Life <input type="checkbox"/> Remove Child Life

Section 4: Acceptance

I understand that my coverage is subject to the provisions of the policy between FCPS and MetLife, including underwriting guidelines of the plan. Any guaranteed insurance will be effective only if this application is received in the Office of Benefit Services prior to the end of the enrollment period. I authorize payroll deductions to be made as required for the coverage elected above. If I have elected dependent coverage, I understand I am responsible for notifying the Office of Benefit Services when I no longer have dependents that qualify for coverage under the plan.

Signature: _____

Date: _____

To submit your completed form:

- Scan and email 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

If you fax your form, remember to **keep a copy for your records** as well as 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. You are encouraged to log onto UConnect 7 business days after successfully sending your completed paperwork to the Office of Benefit Services to verify your request was processed.

Questions? Contact the Office of Benefit Services at calling 571-423-3200, Option 3, or email your questions to [FCPS StaffConnect](#).