Retiree Medical & Dental Enrollment and Change Form

Action requested due to: (check all that apply)

☐ Retirement	☐ Utilizing One Time Re-Entry Right	☐ Re-employed Retiree Terminating Active Employment
☐ Cancelling Coverage	☐ Changing Plans due to Medicare Eligibility	☐ Adding or Dropping Dependents
☐ Open Enrollment	☐ Other (describe): _____	
Requested Effective Date of Change: _____		

To ensure your request is processed as quickly as possible, please read the instructions and important information below:
Requested elections/changes to your coverage must be made **within 30 calendar days** of the event. See page 2 for the effective date of change.
If you are requesting to add dependents not currently covered on your FCPS plan, you must supply required supporting documentation. Find a complete list of documentation requirements at www.fcps.edu; search keywords "dependent eligibility".

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 _____

Email Address _____ Alternate Phone _____

Are you the surviving spouse of an FCPS employee/retiree? ☐ Yes ☐ No

If yes, please provide the name and SSN or EIN of the employee/retiree: _____

2a. Medical Plan Election

I would like to: ☐ **Enroll/change coverage** (Complete Sections 2b and 2c) ☐ **Cancel/decline coverage**

2b. Choose a Medical Plan

☐ Aetna Medicare Advantage (Medicare Members) and/or Cigna Open Access Plan (non-Medicare Members)

Medicare members: Aetna Medicare Advantage & SilverScript

Non-Medicare members: Cigna Open Access Plus & CVS Caremark

☐ Kaiser Permanente

Medicare members: Kaiser Permanente Medicare Advantage

Non-Medicare members: Kaiser Permanente Signature HMO

Note: Electing a Medicare Advantage plan requires enrollment in Medicare Part A & Part B.
All retirees/covered dependents must enroll in Medicare Parts A & B when first eligible.

2c. Select Your Level of Coverage

Coverage for yourself only	Coverage for yourself + 1 dependent	Coverage for yourself and 2+ dependents
☐ Individual (no Medicare)	☐ Retiree + 1 (no one has Medicare)	☐ Family (no one has Medicare)
☐ Individual (Medicare)	☐ 1 Individual + 1 Medicare (one has Medicare, and one does not)	☐ Family with Medicare (1 or more has Medicare)
	☐ Double Medicare (both have Medicare)	

3a. Dental Plan Election

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

3b. 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).

3c. Select Your Level of Coverage

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

For ERFC Use Only: Payment Source: ☐ Annuity Deduction ☐ Direct Bill

SSN or EIN ____________________

4. If you are electing FCPS Medical coverage, are you eligible for Medicare Parts A & B due to age or disability?
Note: If not enrolling in FCPS medical coverage, go to Section 5 (if electing dental).

☐ Yes If Yes, please provide your Medicare Beneficiary Identifier (MBI): ____________________

☐ No Part A Effective Date: ____________________ Part B Effective Date: ____________________

Please attach a copy of your card to this form.

____________ Retiree Initials	I understand that it is my responsibility (and the responsibility of my covered dependents) to apply for Medicare Parts A & B when first eligible and provide a copy of my Medicare card to the Office of Benefit Services within 30 calendar days of receipt. Failure to apply for Medicare Parts A & B, including eligibility due to disability, will result in cancellation of medical coverage.

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) **and Social Security Number** (see box 9)	**Gender, Relationship, and D.O.B.**	**Plans to Enroll In**	**Medicare Info** (Attach copy of Medicare card. If you are not enrolled in Medicare, please skip this section.)
Dependent Name ____________ SSN ____________	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY) ____________	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental	**Medicare Effective Date:** Part A ____________ Part B ____________ MBI# ____________
Dependent Name ____________ SSN ____________	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY) ____________	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental	**Medicare Effective Date:** Part A ____________ Part B ____________ MBI# ____________
Dependent Name ____________ SSN ____________	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY) ____________	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental	**Medicare Effective Date:** Part A ____________ Part B ____________ MBI# ____________

6. Remove Dependents
Complete only if YOU, the retiree, 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**	**Remove from**
____________	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY) ____________	☐ Medical ☐ Dental ☐ Medical & Dental
____________	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY) ____________	☐ Medical ☐ Dental ☐ Medical & Dental
____________	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY) ____________	☐ Medical ☐ Dental ☐ Medical & Dental

Coverage Effective Dates:

- If enrolling for coverage as a newly retired employee, you must submit this form **within 30 calendar days of your date of retirement.** Coverage will then take effect on the first day of the month following your date of retirement. If your date of retirement is the first day of the month, retiree coverage will become effective on that date.
- If requesting a change in enrollment due to a family status change or qualifying event, your request must be submitted **within 30 calendar days of the status change or qualifying event,** with changes in coverage effective the first day of the month after the qualifying event. You will need to supply the required supporting documentation. Find a complete list of documentation requirements at www.fcps.edu; search keywords **"dependent eligibility".**

SSN or EIN _____

7. Acceptance or Opt Out

I hereby elect (or decline) coverage under the FCPS health plan 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 the following provisions apply:

- I must notify the Office of Benefit Services of any change in status which would cause me - or my enrolled dependents - to cease to be eligible for benefits under the FCPS health and/or dental plans. This includes the death of a covered dependent, divorce, or a dependent child reaching the maximum age limit.
- If I am the surviving spouse of a deceased employee/retiree, I must notify the Office of Benefit Services **within 30 calendar days** if I remarry. Reminder - I am not eligible for FCPS coverage if I remarry.
- 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.
- If I elect coverage for myself but choose not to cover my eligible dependent(s), I may only add dependents during Open Enrollment or **within 30 calendar days** of a qualifying event. Examples of qualifying events include eligibility for Medicare, termination of spouse's employment, significant increase in my dependent's cost of coverage, and/or loss of eligibility under spouse's health and/or dental plan. See the *FCPS Retiree Benefits Handbook* for more information.
- I have the ability to cancel FCPS coverage and re-enter the plan(s) at a later date if I meet all of the following criteria:
  - I was enrolled in an FCPS medical and/or dental plan on the date immediately prior to my retirement; **and**
  - I am eligible to enroll in FCPS retiree coverage based on FCPS regulations; **and**
  - I am enrolled in Medicare Parts A, B, and D or a Medicare Advantage Plan with pharmacy benefits. If I wish to cover my dependents, all dependents must be enrolled in Medicare (same parts as above); **and**
  - I apply for coverage within 30 days of a qualifying event (or during Open Enrollment); **and**
  - I provide proof of other continuous health/dental coverage for the preceding 12 or more consecutive months; **and**
  - I have not previously utilized my re-entry right.
- It is my responsibility to keep my address up to date with my Retirement Agency (or the Office of Benefit Services, if no longer receiving a retirement benefit) and remain informed of any changes to the plan that might affect my eligibility or my dependent(s) eligibility.
- By completing and signing this enrollment form, I am making a binding election with regard to my benefits. I authorize FCPS to take the necessary deduction from my retirement annuity to pay my share of the cost of coverage, including any retroactive deductions if required. This authorization applies to future plan years unless I modify or cancel my coverage. If my retirement annuity will not accommodate the deduction, I will be invoiced by OptumFinancial Services.

Retiree Name (Last, First, MI): _____

Retiree Signature: _____ **Date:** _____

8. Submission

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

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

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. Notes

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 required 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.

Nondiscrimination and Foreign Language Assistance:
FCPS health plans comply with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act (Nondiscrimination in Health Programs and Activities). In compliance with the Act, FCPS health plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. FCPS health plans also prohibit denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping. The Plan also provides important protections for individuals with disabilities and enhances language assistance for people with limited English proficiency. Each tagline listed below reads, "If you speak [native language], language assistance services, free of charge, are available to you. Call 571-423-3200."

ENGLISH
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 571-423-3200.

AMHARIC (አማርኛ)
አዳምጥ : አማርኛ , ከክፍያ ነፃ የቋንቋ እርዳታ አገልግሎቶች , የሚናገሩ ከሆነ , ለእርስዎ የሚገኙ ናቸው . 571-423-3200 ይደውሉ .

ARABIC (العربية)
تنبيه: إذا كنت تتكلم العربية ، وخدمات المساعدة اللغوية ، مجانا ، تتوفر لك .تملاكم 571- 423- 3200.

BENGALI (বাংলা)
দৃ আকষণর্ : আপিন বাংলা , ভাষা সহায়তা সেবা , নিখরচা কথা বলেত পারেন আপনার জনয্ উপল . 571-423-3200 কল .

CHINESE (繁體中文)
注意：如果你 说中国话，语言协助服务，免费的，都可以给你。拨打 571-423-3200。

FRENCH (Français)
ATTENTION : Si vous parlez français , les services d'assistance de langues, gratuitement , sont à votre disposition. Appelez 571-423-3200.

GERMAN (Deutsch)
ACHTUNG: Wenn Sie Deutsch sprechen , Sprachassistenzdienste sind kostenlos, zur Verfügung. Rufen Sie 571-423-3200 .

HINDI (?हंद)
ध्यान द : आप ?हंद , भाषा सहायता सेवाओं , ?न : शुल्क बोलते ह ,तो आप के ?लए उपलब्ध ह । 571-423-3200 बुलाओ।

IBO (Igbo asusu)
Ntị : Ọ bụrụ na ị na-ekwu okwu n'ala Igbo , asụsụ aka ọrụ , n'efu , dị ka gị. Akpọ 571-423-3200 .

KOREAN (한국어)
주의 : 당신이 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다 . 571-423-3200 를 호출합니다.

KRU (Bàsɔ́ ɔ̀-wùɖù-po-nyɔ̀)
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ Bàsɔ́ ɔ̀-wùɖù-po-nyɔ̀ jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 571-423-3200.

PERSIAN FARSI (فارسی)
پاسخ : اگر شما فارسی صحبت می کنند ، خدمات کمک زبان رایگان در دسترس شما هستند توجه . 571- 423- 3200 .

RUSSIAN (Русский)
ВНИМАНИЕ : Если вы говорите России , переводческие услуги , бесплатно , доступны для вас . Звоните 571-423-3200 .

SPANISH (Español)
ATENCIÓN : Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame a 571-423-3200.

TAGALOG (Tagalog)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 571-423-3200.

URDU (اُردُو)
اگر آپ اردو بولتے ہیں تو ، مفت زبان کی مدد کی خدمات آپ کو دستیاب ہیں توجہ :. 571- 423- 3200 پر کال کریں.

VIETNAMESE (Tiếng Việt)
Chú ý : Nếu bạn nói tiếng Việt , các dịch vụ hỗ trợ ngôn ngữ , miễn phí, có sẵn cho bạn . Gọi 571-423-3200 .

YORUBA (èdè Yorùbá)
AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 571-423-3200.