



# Retiree Medical & Dental Enrollment and Change Form

Action requested due to: (check all that apply)

<input type="checkbox"/> Retirement	<input type="checkbox"/> Utilizing One Time Re-Entry Right	<input type="checkbox"/> Re-employed Retiree Terminating Active Employment
<input type="checkbox"/> Cancelling Coverage	<input type="checkbox"/> Changing Plans due to Medicare Eligibility	<input type="checkbox"/> Adding or Dropping Dependents
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> 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](http://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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide the name and SSN or EIN of the employee/retiree: _____		

**2a. Select Your Medical Plan - or -  Cancel/decline coverage**

<input type="checkbox"/> Aetna	<input type="checkbox"/> CareFirst	<input type="checkbox"/> Kaiser Permanente
<i>Non-Medicare members: Aetna/Innovation Health &amp; CVS Caremark</i>	<i>CareFirst BlueChoice Advantage &amp; CVS Caremark</i>	<i>Non-Medicare members: Kaiser Permanente Signature HMO</i>
<i>Medicare members: Aetna Medicare Advantage &amp; SilverScript</i>	<i>Plan not available if retiree or covered dependent is eligible for Medicare</i>	<i>Medicare members: Kaiser Permanente Medicare Advantage HMO</i> <b>(Completion of additional form is required)</b>

**2b. Select Your Level of Coverage**

Coverage for yourself only	Coverage for yourself + 1 dependent	Coverage for yourself and 2+ dependents
<input type="checkbox"/> Individual (no Medicare)	<input type="checkbox"/> Mini-family (no one has Medicare)	<input type="checkbox"/> Family (no one has Medicare)
<input type="checkbox"/> Individual (Medicare)	<input type="checkbox"/> 1 Individual + 1 Medicare (one has Medicare/one does not)	<input type="checkbox"/> Family with Medicare
	<input type="checkbox"/> Medicare Mini-family (both have Medicare)	<input type="checkbox"/> Mini-family + 1 Medicare

**3a. Select Your Dental Plan - or -  Cancel/decline coverage**

<input type="checkbox"/> Aetna Dental PPO	<input type="checkbox"/> Aetna Dental DNO If electing the DNO plan, you MUST contact Aetna Dental to designate a primary care dentist (PCD).
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**3b. Select Your Level of Coverage** (Note: separate premium structures apply to retirees/dependents age 65+)

Coverage for yourself only	Coverage for yourself + 1 dependent	Coverage for yourself and 2+ dependents
<input type="checkbox"/> Individual	<input type="checkbox"/> Mini-family	<input type="checkbox"/> Family

<b>For Benefits Office Use Only:</b>	Payment Source:	Eligible?
	<input type="checkbox"/> Annuity Deduction	<input type="checkbox"/> Yes
	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> No

**SSN or EIN** \_\_\_\_\_

**4. If you are electing FCPS Medical coverage, are you eligible for Medicare 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.**

I understand that it is my responsibility (and the responsibility of my covered dependents) to apply for Medicare 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, 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	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental Only <input type="checkbox"/> Both Medical & Dental	<b>Medicare Effective Date:</b> Part A _____ Part B _____ MBI# _____
_____ Dependent Name _____ SSN	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental Only <input type="checkbox"/> Both Medical & Dental	<b>Medicare Effective Date:</b> Part A _____ Part B _____ MBI# _____
_____ Dependent Name _____ SSN	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental Only <input type="checkbox"/> Both Medical & Dental	<b>Medicare Effective Date:</b> 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
_____ _____ _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Medical & Dental
_____ _____ _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Medical & Dental
_____ _____ _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Medical & Dental

**Coverage Effective Dates:**

- 1 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.
- 1 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](http://www.fcps.edu); search keywords "dependent eligibility".

**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 continuous health 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 email form to: [HRBenefitsDocumentation@fcps.edu](mailto:HRBenefitsDocumentation@fcps.edu)

Or fax to: Office of Benefit Services at 571-423-5000

Or mail to: Department of Human Resources  
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 email your questions to [HRConnection@fcps.edu](mailto:HRConnection@fcps.edu).

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 , ከከፍተኛ ነፃ የቋንቋ እርዳታ አገልግሎቶች , የሚናገሩ ከሆነ , ለእርስዎ የሚገኙ ልዩ ልዩ ሰጠው . 571-423-3200 ይደውሉ .

#### ARABIC (عربى)

تنبيه: إذا كنت تتكلم العربية ، وخدمات المساعدة اللغوية ، مجاناً ، تتوفر لك . 571-423-3200

#### BENGALI (বাংলা)

দ্রষ্টব্য : আপনি বাংলা , ভাষা সহায়তা সেবা , নিখরচা কথা বলেত পারেন আপনার জনস্ব উপলব্ধ . 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 , Sprachassistentendienste sind kostenlos, zur Verfügung. Rufen Sie 571-423-3200 .

#### HINDI ( ? हंदी )

ध्यान दें : आप ? हंदी , भाषा सहायता सेवाओं , ? न : शुल्क बोलते हों , तो आप के ? लए उपलब्ध हों । 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 ( )

: . 571-423-3200

#### KRU (Bàsó ò-wùdù-po-nyò)

Dè dè nià kè dyédé gbo: Ọ jù ké m̀ Bàsó ò-wùdù-po-nyò jù ní, níí, à wuqu kà kò dọ po-poò bèin m̀ gbo kpáa. Dá 571-423-3200.

#### PERSIAN FARSI (پسراف)

پاسخ : اگر شما فارسی صحبت می کنید ، 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 (اردو)

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 Yorùbá ọfẹ ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 571-423-3200.