

Fairfax County Government Benefits Enrollment/Change Form - Employee

Please send the completed and signed form to the Department of Human Resources at 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 or fax to 703-802-8795. If you fax the form, remember to 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 will not be accepted.

EMPLOYEE NAME	SOCIAL SECURITY OR PERSONNEL NUMBER	HIRE DATE
HOME PHONE	WORK PHONE	E-MAIL
		DATE OF EVENT

Why I'm submitting this form (see Fairfax Net for more information):

- Open Enrollment** (only submit form if changes are being made)
- Newly eligible:** new employee or newly eligible for benefits.
- Change in enrollment status of employee or dependent that affects eligibility or cost of coverage:** termination or commencement of benefits-eligible employment or FMLA leave, change in worksite, schedule, employer contributions, spouse's open enrollment, etc.
- Change in number of dependents:** birth, adoption, guardianship, marriage, divorce, legal separation, court orders, termination or commencement of Medicaid or SCHIP, etc.
- Other:** Change in daycare providers or cost of daycare, LTD election/change.

Newly eligible employees should complete all sections. For changes due to qualified events, only complete sections that are changing. (Documentation about the qualified event is required.)

Section A. Medical and/or Dental Coverage – (Select the plan, level of coverage, and tell us about those who should be covered)						
Medical/Dental				Waive Coverage		
County Medical Plan Managed by CIGNA	Individual	2 Party	Family	Number with Medicare	<input type="checkbox"/> Waive medical*	<input type="checkbox"/> Waive Dental*
<input type="checkbox"/> OAP Copay Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Note: Only coverage in effect may be continued into retirement.	
<input type="checkbox"/> OAP 90% Coinsurance Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<input type="checkbox"/> OAP 80% Coinsurance Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<input type="checkbox"/> HMO Managed by Kaiser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<input type="checkbox"/> Delta Dental PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
All medical plan enrollments automatically include vision benefits through Davis Vision.						
Enrollment Information – must be completed for each individual to be covered under health and/or dental coverage						
Name (Last, First, MI)	Birthdate (MM/DD/YY)	S e x	Relationship: (child, stepchild, guardianship, etc.)	Social Security or Personnel Number	Enroll in Health Plan	Enroll in Dental Plan
			Employee		<input type="checkbox"/>	<input type="checkbox"/>
			Spouse		<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
Note: If adding spouse and/or dependent children, <u>you must forward the marriage certificate and/or birth certificates</u> to Benefits in the Department of Human Resources before your enrollment request will be processed. Dependents not listed above will not be covered. You must notify plan if you are to continue to be covered by a second health or dental plan so coordination of benefits may be arranged.						
To Remove a Dependent	Please remove the dependent listed below from the benefits indicated.					
Dependent to be dropped:	Reason for Dropping	Date Occurred:	Drop from:			
			<input type="checkbox"/> Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Both health and dental	
			<input type="checkbox"/> Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Both health and dental	
			<input type="checkbox"/> Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Both health and dental	
			<input type="checkbox"/> Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Both health and dental	

Section B. Group Term Life Insurance (See Fairfax Net for a description of changes that may be made. Coverage may be contingent on approval by the Life Insurance company.) **To elect a beneficiary other than your estate, complete and return a Beneficiary Election Form.**

Basic Coverage: Paid for in full by the County.

1x annual salary

Additional Optional Employee Coverage: Optional Coverage – paid for in full by the Employee. **Please select one:**

1x annual salary 2x annual salary 3x annual salary 4x annual salary

Waive or Cancel. **I DO NOT** wish to enroll for optional employee coverage or I am requesting cancellation of this coverage. I understand that once coverage is waived or cancelled, I will be required to furnish evidence of insurability if I wish to become insured at a later date.

Dependent Coverage Please select one:

\$10,000 spouse/\$5,000 children; or \$15,000 spouse/\$7,500 children

Waive or Cancel. **I DO NOT** wish to enroll my eligible dependents for life insurance coverage or I am requesting cancellation of this coverage. I understand that once coverage is waived or cancelled, I will be required to furnish evidence of insurability for eligible dependents if I wish to insure them at a later date.

Section C. Flexible Spending Account Programs (Indicate annual amount to be contributed or click the box to waive/cancel participation)

Medical Spending Account (\$2,500 maximum)

Contribute \$_____ for calendar year _____. Waive or cancel participation in the Medical Spending Account.

Dependent Care Account (day care) (\$5,000 maximum)

Contribute \$_____ for calendar year _____. Waive or cancel participation in the Dependent Care Spending Account.

Section D. Long Term Disability (No qualified event required. Enrollment after 30 days of eligibility contingent on approval by LTD provider.)

Enroll in Long Term Disability. Waive or cancel participation in the Long Term Disability
(Preexisting conditions during the 90 day period preceding the effective date of coverage are not covered.)

To Enroll, Change or Cancel Other Voluntary Benefits

Deferred Compensation

To enroll or change deferral amount, participants may visit rps.troweprice.com or call 888-457-5770.

Acceptance: I hereby apply or waive 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 my employer. I understand that I must submit my election within 30 days of becoming eligible and that this coverage is not in effect until my election has been accepted by Human Resources. I also understand that this election is made under the IRS Pre-Tax Rules and Regulations. The effective date for my enrollment as a newly-eligible employee shall be the first of the month after Human Resources receives the completed enrollment. I further understand that I cannot cancel or change this election unless I experience a Change-in-Status or am entitled to a Special Enrollment Right under HIPAA.

I understand that I must notify the Benefits Office in Human Resources 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 County's health, dental or life insurance plans due to the dependent's death or loss of eligibility. If I fail to notify the Benefits Office in Human Resources 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 or my dependent(s) eligibility. If I am requesting a change in my benefit election it must be necessitated by, and consistent with, the change in family status and the change must be acceptable under the IRS Pre-Tax Regulations. The effective date for the change and the documentation that must be submitted are described in the Benefits Summary Handbook.

I also certify that the dependents listed above are eligible to be covered as dependents as described in the Fairfax County Benefits Handbook.

I hereby authorize any physician, hospital or other provider of service to furnish any information, reports or copies of records, related to care or services rendered to me or any of the dependents listed above to the insurance carrier(s) or other third parties who require such information to administer the plan. Such information is to be held confidential. 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 my employer to make the deductions necessary to pay my share of the cost of coverage. I also authorize subsequent payroll deductions in future plan years unless I notify my employer of a change in my election. See Summary Benefits Handbook for more information.

Employee Signature: _____ Date: _____

Mail completed form to: Department of Human Resources
12000 Government Center Parkway, Suite 270
Fairfax, Virginia 22035
Or fax to: 703-802-8795