

Fairfax County Government Benefits Retiree Enrollment/Change Form

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.

RETIREE NAME	SOCIAL SECURITY OR PERSONEL NUMBER	
HOME PHONE	WORK PHONE	E-MAIL

Note: If you are not currently enrolled in a benefit, you may not elect it as a retiree.

This form is for
Open Enrollment *changes* for 2015 only.

Return this form only if you are making a change to your coverage.

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		
<input type="checkbox"/> 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"/>	_____	Remember that you are required to apply for, maintain and send in a copy of your Medicare card showing Part A and Part B coverage when you receive it due to age or disability.	
<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 <i>(change coverage level only)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No new coverage.		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)	Sex	Relationship: (child, stepchild, guardianship, etc.)	Social Security or Personnel Number	Enroll in Health Plan	Enroll in Dental Plan
			Retiree		<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"/>
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			

If you are eligible for Medicare, you are required to submit proof of Medicare Part A and Part B coverage (and maintain that coverage) in order to be eligible for retiree health insurance. Apply three months before your eligibility date.

To Enroll, Change or Cancel Other Voluntary Benefits	
Group Term Life Insurance	To reduce or cancel your life insurance coverage or to change your beneficiary, request a form from HR-Central at 703-324-3311.
Deferred Compensation	To arrange for withdrawals or to change investments, 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 or during open enrollment and that this coverage is not in effect until my election has been accepted by Human Resources.

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, divorce or other 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. The effective date for the change and the documentation that must be submitted are described in the Benefits Summary Handbook.

***I understand that if I ever stop being covered by a Fairfax County health or dental plan as a retiree, dependent or re-employed annuitant, I can never enroll in that coverage in the future.**

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 pension deductions in future plan years unless I notify my employer of a change in my election. See Summary Benefits Handbook for more information.

Retiree 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