

Fairfax County Government Benefits Retiree Enrollment/Change Form

Once this form is completed, please send it 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 _____ RETIRE DATE (if new) _____

HOME PHONE _____ WORK PHONE _____ E-MAIL _____ DATE OF EVENT _____

RESIDENCE PHYSICAL ADDRESS (Required if system address is a post office box) _____ City _____ State _____ Zip Code _____

New retirees should complete all sections. Note: If you are not currently enrolled in a benefit, you may not elect it as a retiree. If you are eligible for Medicare, you are required to provide proof of Medicare Part A and Part B coverage in order to maintain retiree health insurance.

I'm submitting this form for:

- New Retiree
- Change in number of dependents
- Other: Eligibility for Medicare, change to physical address (for those with P.O. Boxes as mailing address), moved from plan's service area.

Section A. Medical and/or Dental Coverage – (Select the plan, level of coverage, and tell us about those who should be covered)

Medical/Dental	Individual	2 Party	Family	Number with Medicare	Permanently Cancel Coverage	
County Medical Plan Managed by CIGNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Cancel medical*	<input type="checkbox"/> Cancel 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"/>	_____	All medical plan enrollments automatically include vision benefits through Davis Vision.	
<input type="checkbox"/> Delta Dental PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

**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.*

Enrollment Information – must be completed for each individual to be covered under health and/or dental coverage

Name (Last, First, MI)	Birthdate	Sex	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, you must forward the marriage certificate and/or birth certificates 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 will 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. Retiree Group Term Life Insurance:

Note: Reduces to 65% of original coverage at retirement; 30% at age 70.

You may elect to continue or decrease the coverage level you currently have; no increases are permitted.

Please complete and return a current Beneficiary Election Form.

Basic Coverage:

- 1x annual salary
- Reduce my coverage to \$12,500 Basic Coverage **Only** (Note: dependent coverage cannot be higher than \$12,500).
- Cancel. I **DO NOT** wish to continue basic retiree coverage. **I understand that I can never enroll in the future.**

Optional Coverage:

Note: Optional coverage is not available if coverage has been reduced to \$12,500.

Please select one:

- 1x annual salary 2x annual salary 3x annual salary 4x annual salary
- Cancel. **I understand that I can never enroll in the future.**

Dependent Coverage:

Note: Dependent coverage may not exceed the total of your retiree coverage. Dependent children covered to age 26.

Please select one:

- \$10,000 spouse/\$5,000 child(ren); or \$15,000 spouse/\$7,500 child(ren)
- Cancel. I **DO NOT** wish to continue dependent coverage

To Enroll, Change or Cancel Other Voluntary Benefits

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 cancel 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. The effective date for my enrollment as a newly-eligible employee shall be the first of the month after my eligibility date.

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 stay informed of any changes to the plan that might affect me or my dependent(s) eligibility. The effective date for the change and the documentation that must be submitted are described on the fairfaxNet Benefits webpage.

***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 on the fairfaxNet Benefits web page.

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 the fairfaxNet Benefits web page 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