

HEALTH INSURANCE ELECTION/CHANGE FORM

Benefits Open Enrollment – November 1-30, 2010

(Changes Effective January 1, 2011)

Complete this form ONLY IF MAKING A CHANGE TO YOUR CURRENT COVERAGE OPTIONS

Retiree Information (Please Print):

Retiree's Name _____ Social Security # _____

Retiree's Date of Birth _____

Please check this box to indicate that you have supplied information about spouse or dependants on the reverse.

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

I Currently Have:

CIGNA OAP

[If you make no election at right, or do not return this form, your coverage will automatically move to OAP-High (CIGNA)]

CareFirst BluePreferred PPO

CareFirst PPO is NOT available for 2011

[If you make no election at right, or do not return this form, your coverage will automatically move to OAP-High (CIGNA)]

CareFirst Blue Choice POS

Kaiser HMO

I currently have coverage for:

1 Individual 2 Individuals Family

How many with Medicare? _____

My Election for 2011

OAP-High + Vision (administered by CIGNA)

OAP-Low + Vision (administered by CIGNA)

POS + Vision (administered by CareFirst)

POS Primary Care Doctor's Name/Code _____

HMO + Vision (administered by Kaiser*)

In 2011, I need coverage for: 1 Individual

2 Individuals Family (list all names & other info on back)

How many with Medicare? _____

*I hereby acknowledge receipt of the **Open Enrollment Materials** from Fairfax County with new election options for health insurance for 2011. **Please Note:** If you currently have the CareFirst PPO plan or CIGNA and we do not receive this form back from you, your coverage will automatically be transferred to the **CIGNA OAP High Option Plan** with Davis Vision. New premium rate will take effect with deductions in the December 2010 payroll. All changes are effective January 1, 2011.*

Forms must be received by RAA no later than November 30, 2010.

Signature _____ Date _____

* Kaiser coverage is not available if you or your spouse are over the age of 65. New Kaiser enrollees for 2011 MUST contact RAA to receive a Kaiser enrollment form.

Complete the Information Below
If you are Requesting Coverage for More than 1 Individual

All insured members must be listed below by name, and include date of birth, Social Security Number and their relationship to the applicant.

Additionally, if you have elected the POS plan, you must also include a Primary Care Physician name and Code for each covered family member.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH M/D/YEAR	RELATIONSHIP TO APPLICANT	PRIMARY CARE PHYSICIAN* Only designate PCP if you are electing the POS – (CareFirst)	PCP CODE* Only if you are electing POS – (CareFirst)	COVERED BY MEDICARE? YES/NO
_____	_____	_____	_____	Retiree			
Social Security Number: _____							
_____	_____	_____	_____	Spouse (if applicable)			
Social Security Number: _____							
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							

**Only designate a PCP and Code if you are electing the Point of Service (POS) option administered by CareFirst.*

----- The Retirement Agency MUST RECEIVE this COMPLETED form
NO LATER THAN November 30, 2010 -----

If you are NOT making changes to your coverage from 2010, you do NOT need to complete and return this form.

Fairfax County Retirement Administration Agency

10680 Main Street, Suite 280, Fairfax, VA 22030

703-279-8200 ~ 800-333-1633 ~ FAX 703-273-3185

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