Benefits Enrollment Form
Open Enrollment
Effective July 1, 2022

YOUR INFORMATION – Please Print

Name: _____ **Employee ID #:** _____
Last First Middle Initial

Home Address: _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____

MEDICAL – *Please mark one box*

☐ **No Coverage** – *I elect to waive medical coverage*

Kaiser HMO
- ☐ **Employee Only**
- ☐ **Employee + One Dependent**
- ☐ **Family**

United Health Care Choice Plus (POS) with CareFirst CVS Rx
- ☐ **Employee**
- ☐ **Employee + One Dependent**
- ☐ **Family**

United Healthcare QHP with Health Savings Account – Must Complete HSA Form
- ☐ **Employee Only**
- ☐ **Employee + One Dependent**
- ☐ **Family**

DENTAL: CareFirst BlueDental Plus– *Please mark one box*

- ☐ **No Coverage** – *I elect to waive dental coverage*
- ☐ **Employee Only**
- ☐ **Employee + One Dependent**
- ☐ **Family**

VISION: EyeMed – *Please mark one box*

- ☐ **No Coverage** – *I elect to waive vision coverage*
- ☐ **Employee Only**
- ☐ **Employee + One Dependent**
- ☐ **Family**

FLEXIBLE SPENDING ACCOUNT: TASC – *Please indicate your election*

Health Care Spending Account: $_____
Contribution Per Pay Period

Maximum contribution per pay period: $118.75

Dependent Care Spending Account: $_____
Contribution Per Pay Period

For Dependent Care FSA, eligible dependents must be under age 13, unless disabled and incapable of self-support

Maximum contribution per pay period: $208.33

DEPENDENTS *(if adding an dependent, proof of eligibility is required)* *Review Summary of Benefits*

Action	Coverage	Name *(First, MI, Last)*	Relationship	Gender	Date of Birth	Social Security Number
☐ Enroll ☐ Cancel	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		
☐ Enroll ☐ Cancel	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		
☐ Enroll ☐ Cancel	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		
☐ Enroll ☐ Cancel	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		
☐ Enroll ☐ Cancel	☐ Medical ☐ Denta ☐ Vision			☐ Male ☐ Female		

ACKNOWLEDGEMENT

I hereby authorize Alexandria City Public Schools to deduct any required contributions from my pay for the elected benefits. The cost of my medical, dental, and/or vision and/or Flexible Spending Account contributions will be deducted from my pay on a pre-tax basis in accordance with Section 125 of the Internal Revenue Code. I understand that my benefit elections will be binding for the entire Plan Year, with an effective date of July 1, 2022, unless I have a qualified change of status as defined by IRS regulations. Deductions for elected benefits will begin with my July 15, 2022 pay. If electing to participate in a Flexible Spending Account plan, I understand that this agreement is only for eligible services provided during the plan year and services must be provided before submission of claims for reimbursement, and that any salary deductions that have not been used for expenses incurred in the plan year will be forfeited in accordance with current law.

Employee Signature: _____ Date: _____

Email or Mail Completed Form No Later than May 27, 2022 to:

HRBenefits@acps.k12.va.us

Human Resources Department
1340 Braddock Place, Suite 520
Alexandria, VA 22314