Benefits Enrollment Form

☐ New Hire ☐ Qualifying Event: ______________________
(Indicate type)

YOUR INFORMATION – Please Print

Name: ____ **SSN or 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 (Max. $114.58)***	**x 24** ***Number of Pay Periods***	**=**	**$________________** ***Annual Election Amount*** *Cannot exceed $2,750*
Dependent Care Spending Account: *For Dependent Care FSA, eligible dependents must be under age 13, unless disabled and incapable of self-support*	**$__________** ***Contribution Per Pay Period (Max $208.33)***	**x 24** ***Number of Pay Periods***	**=**	**$________________** ***Annual Election Amount*** *Cannot exceed $5,000 per household*

DEPENDENTS *(if adding a 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		

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

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 effective the first day of the month following a 30 day waiting period, and any employee contributions will begin with my pay received the month prior to the effective date. 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 to:

HRBenefits@acps.k12.va.us

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