Alexandria City Public Schools

Human Resources Department

Retiree Health Insurance Open Enrollment Form Effective July 1, 2024

PLEASE PRINT

Name: (First, MI, Last) _____

Address: _____

City/State/Zip: _____

Phone: _____

Email Address: _____

Social Security #: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

Medicare Enrolled: ☐ Part A ☐ Part B ☐ N/A

Medicare # _____

Monthly premiums listed below for the medical plans are net of the subsidy. The maximum subsidy is $265 per month. Please check appropriate box from each section below.

MEDICAL – please mark one box

☐ No Coverage – I elect to waive medical coverage and understand I cannot elect medical coverage in the future.

Kaiser HMO

☐ Retiree Only
☐ Dependent of Retiree
☐ Retiree + One
☐ Retiree + Family

Kaiser Medicare Plus*

☐ Retiree Only
☐ Dependent of Retiree

UHC Choice Plus (POS)

☐ Retiree Only
☐ Dependent of Retiree
☐ Retiree + One
☐ Retiree + Family

UHC Medicare Advantage*

☐ Retiree Only
☐ Dependent of Retiree

**If you elect a Medicare plan, you must also complete a separate provider application. Contact Benefits Office for details.*

DENTAL – CareFirst – please mark one box

☐ No Coverage– I elect to waive dental coverage and understand I cannot elect dental coverage in the future.
☐ Retiree Only
☐ Dependent of Retiree
☐ Retiree + One
☐ Retiree + Family

VISION–EyeMed - *please* mark one box

☐ No Coverage– I elect to waive vision coverage and understand I cannot elect vision coverage in the future.
☐ Retiree Only
☐ Dependent of Retiree
☐ Retiree + One
☐ Retiree + Family

DEPENDENTS - If adding a dependent, proof of eligibility is required. Coverage for dependents will not be made effective until appropriate documentation is received by the Benefits Office.

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		

Acknowledgement

I understand the benefit elections once I retire and any monthly premium payments will be as follows:

- If I elect the United Healthcare Medicare Advantage Plan or Kaiser Medicare Plus, I must return the provider application to ACPS Human Resources Benefits Office. I further understand that I will be notified of my application status directly from the provider (either Kaiser or United Healthcare).
- If I elect the United Healthcare Medicare Advantage plan, I will receive a monthly invoice from United Healthcare (UHC), and I will remit my premiums directly to UHC.
- If my spouse is enrolled in Kaiser Medicare Plus, I have the option of having the premium deducted from my VRS pension payments or direct billing from Kaiser.
- If I elect any of the other coverage listed above, my total monthly premium will be deducted from my VRS Retirement payments, if applicable, otherwise I must pay ACPS directly.
- If I am a Surviving Dependent of a Retiree, I must pay ACPS directly.
- If I elect to terminate any coverage with ACPS I will not be eligible to re-enroll at a later date.
- To pay ACPS directly, make checks payable to ACPS and mail to the attention of Connie Snyder-Felix, 1340 Braddock Place, Suite 610, Alexandria, VA 22314.

Please note, failure to pay the monthly premium on time or within the 30-day grace period, will result in cancellation of your health insurance coverage and you will not be able to re-enroll at a later date.

_____ _____

Signature Date

Email or Mail Completed Form No Later than June 12, 2024 to:

HRBenefits@acps.k12.va.us

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

May 2024