Alexandria City Public Schools

**Human Resources Department**

# Retiree Health Insurance Enrollment Form

**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.
- 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