



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. \$118.75)

Annual Election Amount
Cannot exceed \$2,850

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)

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
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Male <input type="checkbox"/> 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