

How to Complete the Retiree Health Insurance Enrollment / Change Form

Click on this link to be directed to the [Retiree Health Insurance Enrollment / Change Form](#).

Select your type of request accordingly:

- New Enrollment = going from active employee to retiree
- Change = retiree electing change such as dropping a dependent
- Cancellation = retiree electing cancel coverage
- Open Enrollment = retiree electing to change plans during Open Enrollment

Complete your personal information.

Any fields marked with an asterisk * are required.

Type of Request

Retiree Information

Date

New Enrollment
Change
Cancellation
Open Enrollment

New Enrollment

If you are covering one or more dependents, select the appropriate coverage level and complete your dependents' information under "List your Dependent and Select Plan"

You must select the health plan under which you are currently covered. Please refer to the Retiree Health Insurance section of your retirement summary email to confirm the plan under which you are currently covered.

Select Coverage Level *

☐ Retiree Only

☒ Retiree + One

☐ Retiree + Family (3 or more)

Select YOUR Plan *

☐ Cigna Open Access Plus (OAP) Plan

☐ Cigna Point of Service (POS) Plan

☐ Cigna Surround Medicare Supplemental Plan + Cigna RX Medicare (PDP)

All non-Medicare eligible individuals under your coverage must have the same plan.

All Medicare eligible individuals must enroll in Medicare Parts A & B and the Cigna Medicare Surround plus Cigna RX Medicare (PDP) to maintain coverage through LCPS.

List Your Dependents and Select Plan

Option	Relationship to Name Retiree	Social Security Number	Date of Birth	Plan
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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When you select the third plan for “Cigna Surround Medicare Supplemental Plan + Cigna RX Medicare (PDP)”

- Please upload your Medicare card or a Medicare letter listing your Medicare number and enrollment in Parts A & B.
- If you do not have a Medicare card yet, you can skip the Upload section.
- Once you receive your Medicare card showing your enrollment in Part A and Part B, please email (picture or PDF) to LCPSHealthWellness@lcps.org, fax to 571-252-1401, or mail a copy to LCPS Administration Building, 21000 Education Court, Suite 319, Ashburn, VA 20148.

Uploads

Medicare Documentation

Upload

Electronically sign by clicking the “Sign” button on the Laserfiche form. Type your name in the top dialog box and click on the green “Sign” button.

Click Submit.

Certification

As a participant in the Health Benefits Plan, I certify that I understand:

- I have applied for or canceled membership in the above-mentioned health plan for myself and for any eligible dependents listed.
- I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the health plan.
- The information provided above is true and correct to the best of my knowledge.
- If I have applied for spousal or dependent health insurance coverage, the dependents listed on my enrollment form are my legal spouse and/or child(ren) under the age of 26 and, if this is a new election, I agree to provide the necessary documentation verifying this relationship.
- I must notify Employee Benefits within 30 days of any change in status which would cause any of my covered dependents to cease to be eligible for benefits under the health, dental and vision plans. These changes include, but are not limited to, death of a dependent, divorce or reaching the policy age limit.
- If I fail to notify Employee Benefits by filing the appropriate termination and/or change forms, I will be responsible for any claims, and/or premiums paid on behalf of any individual who ceased to be eligible for benefits under the policy.
- It is my responsibility to keep informed of any changes to the plan that might affect me or my dependent(s) eligibility.
- At retirement I may not elect to add dependents for any reason. However, I may elect to decrease or cancel coverage on myself or my dependent(s). This is an irrevocable election.
- I and/or my dependents must elect Medicare Part A&B when eligible, to maintain coverage under an LCPS plan. If Medicare Part A&B are not elected coverage through LCPS will be canceled.
- Non-payment of health insurance premium for longer than 60 days will result in an irrevocable cancellation of my health insurance plan.

This authorization will be effective for this plan year and subsequent years, unless modified by completion and acceptance of a new Retiree Health Insurance Enrollment/Change Form.

Signature *

Sign

Date

Date will be captured on form submission

Submit