LOUDOUN COUNTY PUBLIC SCHOOLS

DEPARTMENT OF BUSINESS & FINANCIAL SERVICES

EMPLOYEE HEALTH, WELLNESS & BENEFITS DIVISION

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Phone (571) 252-1810 Fax (571) 252-1401 Email lcpshealthwellness@lcps.org

RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM

EFFECTIVE DATE______________________

1. Retiree Information	
Retiree Name	Date of Birth (month/day/year)
Retiree Mailing Address (if P.O. Box, also provide residential address)	Retiree Social Security Number and PID
City, State, Zip	Home Phone Number
Home Email Address	Alternate Phone Number

2. Electing or Canceling Your Coverage (select one)		
Option 1: ☐ I do NOT wish to enroll/I want to cancel my coverage in the LCPS retiree health insurance. Initials __________		
Option 2: Select Coverage Level	Select Your Plan **(Non-Medicare Eligible** Retirees)	Select Your Plan **(Medicare Eligible** Retirees)
☐ Retiree Only ☐ Retiree + One ☐ Family (3 or more)	☐ CIGNA Point of Service (POS) ☐ CIGNA Open Access Plus (OAP) *All non-Medicare eligible individuals under your coverage must have the same plan.	☐ Cigna Medicare Surround plus Cigna Rx Medicare (PDP) * All Medicare eligible individuals must enroll in Medicare Part A&B and the Cigna Medicare Surround plus Cigna Rx Medicare (PDP) to maintain coverage through LCPS.

3. List Your Dependents and Select Plan

Remove Change Continue	Relationship to Retiree	Name	Social Security Number	Date of Birth (month/day/year)	Select Plan *(See Section 2 for details)		
					POS	OAP	Cigna Medicare

4. Medicare Coverage - Attach a copy of Medicare Part A&B for any Medicare eligible participants.

Retirees and their dependents must elect Medicare Part A&B when they become eligible in order to maintain LCPS coverage. Please attach a copy of your Medicare card to this form, if applicable.

****The reverse side of this form must be signed in order for elections/changes to be processed****

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 Health, Wellness and 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 Health, Wellness and 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, in order to maintain coverage under an LCPS plan. If Medicare Part A&B are not elected coverage through LCPS will be canceled.
- I understand that it is my responsibility to update VRS directly with any changes to my health insurance premiums (LCPS or Medicare) that would affect my health insurance credit (form VRS-45).
- I understand that I may have the option of having my health insurance premiums deducted directly from my VRS pension payment. I can contact Employee Health, Wellness and Benefits (EHWB) for eligibility requirements and must submit the form (VRS-78) to EHWB for processing.

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.

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Retiree Signature Date