



Retiree Health Insurance Enrollment/Change Form

Open Enrollment: May 1-19, 2023 (Changes Effective July 1, 2023)

Instructions: Complete this form if you are making changes to your medical coverage for a **Pre-Medicare plan only**. If you are not making any changes, do not complete this form as no action is required.

Retiree Name:	SSN Last 4:	Date of Birth (MM/DD/YY):
Mailing Address:	City:	State, Zip:
Main Phone:	Email Address:	

Type of Change: <input type="checkbox"/> Enroll in Coverage / Change Plans <input type="checkbox"/> Add Dependents <input type="checkbox"/> Remove Dependents <input type="checkbox"/> Cancel Coverage	Plan Selection: <input type="checkbox"/> Cigna OAP-In Copay <input type="checkbox"/> Cigna OAP-In Coinsurance <input type="checkbox"/> Cigna Choice <input type="checkbox"/> Kaiser Permanente	Level of Coverage: <input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Retiree + Child(ren) <input type="checkbox"/> Family
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Please indicate any changes impacting your eligible dependents below:

<input type="checkbox"/> Add <input type="checkbox"/> Remain <input type="checkbox"/> Remove	Spouse Name:	SSN:	Date of Birth (MM/DD/YY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Add <input type="checkbox"/> Remain <input type="checkbox"/> Remove	Dependent Name:	Relationship to Retiree:	SSN:	Date of Birth (MM/DD/YY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remain <input type="checkbox"/> Remove	Dependent Name:	Relationship to Retiree:	SSN:	Date of Birth (MM/DD/YY)	<input type="checkbox"/> Male <input type="checkbox"/> Female

Other Health Insurance Coverage:

Do you or your dependents have other medical insurance under a group plan, Medicare, or Medicaid? Yes No

If yes, please provide the following:

Name of Person Covered:	Additional Coverage:	Effective Date:
	<input type="checkbox"/> Other Medical Plan _____ <input type="checkbox"/> Medicare Part A ID# _____ <input type="checkbox"/> Medicare Part B ID# _____ <input type="checkbox"/> Medicaid	

Required Documentation:

For any dependents being added to a medical plan, please return documentation of relationship status with your enrollment form. Please note, this is not a complete list. You can view the entire list by going to arlingtonva.us/retirement

Dependent:	Required Documentation:
Spouse (Note: common law spouses and domestic partners are ineligible)	<ul style="list-style-type: none"> • First and last page of most recent federal tax return if filing <u>jointly</u> OR • First and last page of most recent federal tax return if filing <u>separately</u> AND government-issued marriage certificate
Child under age 26	<ul style="list-style-type: none"> • Government-issued birth certificate OR • Hospital-issued birth certificate/letter (for child up to two months old)
Stepchild of your current marriage	<ul style="list-style-type: none"> • Government-issued birth certificate AND • Most recent federal tax return if filing <u>jointly</u> OR • Most recent federal tax return if filing <u>separately</u> AND government-issued marriage certificate

Retiree Certification: *The information provided above is true to the best of my knowledge. I agree to provide required documentation in order to verify my relationship with eligible dependents covered on the insurance plan.*

Retiree's Signature: _____

Date: _____

RETURN COMPLETED FORM TO

Email: benefits@arlingtonva.us / Address: HR-Benefits, 2100 Clarendon Blvd, Suite 511, Arlington, VA 22201 / Fax: (703) 228-3775