COUNTY OF LOUDOUN, VIRGINIA

DEPARTMENT OF HUMAN RESOURCES—BENEFITS DIVISION

1 Harrison St SE, P.O. Box 7000, Leesburg, VA 20177-7000

Benefits Help Line (703) 777-0517/ Fax (571) 258-3212

benefits@loudoun.gov / www.loudoun.gov/retiree

RETIREE HEALTH ENROLLMENT/CHANGE FORM

I. 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
City, State, Zip	Home Phone Number
Email Address	Alternate Phone Number

II. Enroll / Cancel Your Coverage (select one option) EFFECTIVE DATE______________________

Option 1: ☐ I elect NOT to enroll / I want to cancel coverage (select plan/s). ☐ Medical / Prescription ☐ Dental / Vision
I understand that I have the right to waive coverage, and later re-enroll at the same level of coverage in effect at retirement with proof of creditable coverage (requires continued coverage with no lapse in coverage).

☐ I have less than 10 years of service credit with Loudoun County and understand that I am not eligible for coverage under the Retiree Group Health Plan.

☐ I have received a copy of the ***Retiree Group Health Plan Eligibility.*** Initials ________

Option 2: Enroll / Change Select Coverage Level	Select Your Plan **(Non-Medicare Eligible** Retirees)	Select Your Plan **(Medicare Eligible** Retirees)
☐ Retiree Only ☐ Retiree + One (spouse, or child) ☐ Retiree + Family (3 or more) * ***Important Note:*** *You must disclose if you or an enrolled dependent have been diagnosed with end stage renal disease as it may affect your coverage election.* Initials ________	☐ CIGNA Open Access Plus High (OAPH) ☐ CIGNA Open Access Plus (OAP) ☐ CIGNA Choice—Health Reimbursement Arrangement (HRA) ☐ Dental & Vision ** All non-Medicare eligible individuals must be enrolled in the same plan.*	☐ Cigna Medicare Surround + Cigna- HealthSpring Rx (PDP) ☐ Dental ** All Medicare eligible individuals (retirees & dependents) must enroll in Medicare Parts A&B to maintain coverage through LC Retiree Group Health Plan. A copy of all Medicare cards must be attached.*

2(b). List Your Dependents, Select Reason, and Plan (if applicable)

Enroll	Change	Cancel	Name	SSN / Medicare ID	Date of Birth	Relationship Spouse / Child	Select Plan(s) *(See above for details): Dental Vision	OAPH	OAP	HRA	Medicare Surround

III. Premium Payments - Attach a copy of Medicare Part A&B for all Medicare eligible enrollees.

☐ I understand that Flexible Benefit Administrators (FBA) is the administrator of retiree billing services for Loudoun County and that premium payments must be made directly to FBA. ACH is required for premium remittance.

☐ I have received a copy of the ***Benefits Summary & Retiree Group Health Plan Rates.*** Initials ___________

****This form must be initialed in all designated areas and signed on the reverse side in order for elections/changes to be processed****

Certification—As a participant in the Loudoun County Retiree Group Health Plan, I certify and understand the following:

- I may change my enrollment election (remove dependents, change plan type or cancel coverage) only during the annual open enrollment period or **within 30 days of a qualifying event** as specified under the IRC Section 125 Rules and Regulations (refer to *Qualifying Event Changes* document for details).
- I must notify Loudoun County Benefits Division **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 County's Retiree Group Health Plan. These changes include, but are not limited to, death of a dependent, divorce, or dependent child reaching the policy age limit (26 years of age).
- Failure to notify Loudoun County Benefits Division of a timely change in dependent eligibility will result in loss of COBRA continuation rights for that dependent.
- If I fail to notify Loudoun County Benefits Division by completing the appropriate cancellation and/or change form, 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 Plan.
- It is my responsibility to keep informed of any changes to the Plan that might affect me or my dependent's eligibility. Plan information and important updates may be found at **www.loudoun.gov/retiree.**
- **Medicare Enrollment Required—**Retirees (including disability retirees) / spouses and dependent children who are eligible for Medicare Parts "A" &/or "B" must enroll for Medicare coverage.
- It is my responsibility to notify the Loudoun County Benefits Division when I, my spouse or eligible dependent child become eligible for Medicare and **provide proof of enrollment 45 days prior** to the Medicare coverage effective date in order to retain coverage under the Loudoun County Retiree Group Health Plan. Failure to do so may result in cancellation of my group health coverage. If Medicare Parts A&B are not elected, coverage through the Loudoun County Retiree Group Health Plan will be canceled.
- **Failure to make timely payments of my monthly health plan premium may result in an irrevocable cancellation of coverage.** If non-payment is a result of insufficient funds in my designated ACH bank account, I will be responsible for any fees charged as a result. These fees not reimbursable by the Plan or Loudoun County.
- **This authorization will be effective for the current plan year and subsequent years, unless modified by completion and acceptance of a new Health Plan Enrollment / Change Form.**

By signing below, I certify that I have read and understand my obligations and that the information provided herein is true and correct to the best of my knowledge.

____ ____

Retiree Signature Date

EMPLOYER USE ONLY

Length of County Service	**_______Years**	**_______Months**	**______Retiree Group**	**Processed by: (initial / date)**
Benefit Plan:	**Retiree Pays**	**County Subsidy**	**Monthly Premium**	Retirement Analyst
Medical / Rx	$	$	$	
Dental / Vision	$	$	$	Benefits Specialist
Total Premium	$	$	$	
Notes:				

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Revised: 10/16/2023