# Benefits Enrollment and Change Form for Active Employees *(please print)*

***See Page 2 for Instructions and Important Information***

**1.** Employee Last Name: _____ Employee First Name: _____ Middle Initial: _____

Employee #_____ Social Security Number: _____ Daytime Phone Number: _____

Date of Hire: _____ Work Location: _____ Effective Date of Coverage: ***(internal use only)*** _____

**2. Life Event:** ***(only select one)***

**Attach supporting documentation to justify all Life Events. Coverage elections and changes are only allowed if requested within allowed timeframe (usually 31-days) per the list of Life Events.**

- ◯ New Hire
- ◯ Marriage
- ◯ Divorce
- ◯ Birth or Adoption of Child
- ◯ Death of Spouse or Child
- ◯ Dependent Lost Eligibility Status
- ◯ Dependent Gains Eligibility Status
- ◯ Spouse/Dependent Gains other Coverage
- ◯ Spouse/Dependent Loses other Coverage
- ◯ Hours Increased
- ◯ Hours Decreased
- ◯ Unpaid Leave of Absence
- ◯ Open Enrollment
- ◯ Rehired
- ◯ Return from Unpaid Leave of Absence
- ◯ Other (list event below) _____

**3.**

### Medical Coverage

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

SELECT ONE PLAN: ◯ Kaiser Permanente HMO ◯ Cigna Open Access LOW Option ◯ Cigna Open Access HIGH Option

SELECT ONE COVERAGE: ◯ Employee Only ◯ Employee + Spouse ◯ Employee + Child(ren) ◯ Family

### Dental Coverage (with Delta Dental)

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

SELECT ONE COVERAGE: ◯ Employee Only ◯ Employee + Spouse ◯ Employee + Child(ren) ◯ Family

### Vision Coverage (with VSP)

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

SELECT ONE COVERAGE: ◯ Employee Only ◯ Employee + Spouse ◯ Employee + Child(ren) ◯ Family

### Voluntary Disability Buy-Up**

REQUEST: ◯ Enroll ◯ Cancel ◯ Waive

**Employees enrolled in the Virginia Retirement System (VRS) Hybrid Plan are not eligible for the Disability Buy-Up coverage.

### Flexible Spending Accounts

**Flexible Spending Accounts, also known as FSAs, are funded 100% by the employee with pre-tax dollars. Go to www.apsva.us/benefits to learn more about the IRS rules that govern FSA plans.**

#### Health Care FSA

*For eligible **health care expenses** incurred by you and your qualifying dependents.*

**Plan Year:** Your effective date of coverage through December 31st.

**Maximum Annual Election:** **$2,650** (2018 limit)

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

$ _____ Plan Year Election Amount

#### Dependent Care FSA

*For eligible **day care expenses** for qualifying child(ren) and qualifying adult dependents.*

**Plan Year:** Your effective date of coverage through December 31st.

**Maximum Annual Election:** **$5,000** (2018 limit)

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

$ _____ Plan Year Election Amount

#### Parking FSA

Your enrollment, cancellation, or deduction change will be effective the pay period following receipt of your enrollment or change request.

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

$ _____ Monthly Election Amount **$260 maximum** (2018 limit)

#### Transit FSA

Your enrollment, cancellation, or deduction change will be effective the pay period following receipt of your enrollment or change request.

REQUEST: ◯ Enroll ◯ Change ◯ Cancel ◯ Waive

$ _____ Monthly Election Amount **$260 maximum** (2018 limit)

**4. Spouse / Dependent Information:** ***(please print)***

**If you are enrolling your eligible family members for benefits, you will need to provide the dependent's full name, date of birth, and Social Security number. If covering a spouse, you will need to provide a copy of your marriage certificate. If covering a dependent child, you will need to provide a copy of your child's birth certificate, or proof of adoption or legal guardianship.**

| Dependent's Social Security Number | Dependent's Name (Last, First, MI) | Relationship | Gender (M/F) | Dependent's Date of Birth | Medical (Yes / No) | Dental (Yes / No) | Vision (Yes / No) | Add / Drop |
|---|---|---|---|---|---|---|---|---|
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**5.** I hereby request enrollment and authorize deductions from my earnings of the required contributions for the above elected plan(s):

Employee Signature: _____ Date: _____

**Return your completed form and applicable documents to the Human Resources Department.**

APS Human Resources Department ◆ 1426 N. Quincy St., Arlington, VA 22207 ◆ Fax: 703-841-2138 ◆ E-Mail: benefits@apsva.us



***TIP!***

Go to www.apsva.us/benefits to view detailed benefit and coverage information.

# APS Benefits Enrollment and Change Form

## Instructions and Important Reminders:

Complete the "**APS Benefits Enrollment and Change Form**" indicating your coverage elections and/or waivers and return your completed form to the Human Resources Department. (*see contact information at bottom of form*)

### Electing Medical, Dental, Vision, Voluntary Disability Buy-Up *(if eligible)*, Health Care FSA, and Dependent Care FSA

**NEW Employee**: Coverage will begin the on the 1st day of the month following 30-days of employment. You have 31-days from your first day of employment to elect coverage.

**NEWLY-Eligible Employee**: Coverage will begin on the 1st day of the month following the effective date of your new, benefits-eligible position. You have 31-days from your new, benefits-eligible position to elect coverage.

**Electing Parking FSA and Transit FSA** You can enroll or change your Parking and Transit FSA elections at any time during the year. Elections are effective the pay period following your election or change request.

**Waiving Coverage** If you decide not to enroll in coverage, you must complete the "**APS Benefits Enrollment and Change Form.**" Select the "Waive" boxes and return your completed form to Human Resources.

## Electing Coverage for Eligible Dependents:

**Your eligible dependents can also participate in the plans in which you are enrolled:**

**Your lawful spouse:** your spouse is eligible to participate in the plan if he or she is an individual who is recognized as your husband or wife under the laws of the state where you live. *(Common-law spouses are not eligible.)*

***If covering a spouse, you will need to provide a copy of your marriage certificate***.

**Your child(ren):** including your biological child, legally-adopted child (or child placed for adoption), stepchild, foster child, child for whom you are the legal guardian and child you are required to cover under the terms of a qualified medical child support order, to age 26.

***If covering a dependent child, you will need to provide a copy of your child's birth certificate, or proof of adoption or legal guardianship.***

If you are enrolling your eligible family members for benefits, you will need to provide your dependent's full name, date of birth, gender, and Social Security number.