

Arlington Public Schools Retiree Benefits Change Form

Retiree Name (Last, First, MI) _____

SSN #: _____ Medicare Eligible: Yes _____ No _____

Life Event (Select Only One)

Effective Date: **01/01/2025**

- Cancel medical coverage (*cannot be reinstated on a future date*)
- Change medical (*cannot be reinstated on a future date*)
- Death (Please provide copy of death certificate)
- Divorce (Please provide copy of first and last page of divorce decree with court date stamp)

Medical Coverage

Change Cancel (*cannot be reinstated*)

Plan (Select Only One)

- CAREFIRST PPO HIGH Option
- CAREFIRST PPO LOW Option
- CAREFIRST HMO
- Kaiser Permanente Medicare Advantage Plan
- United Healthcare Medicare Advantage Plan

Level of Coverage (Select Only One)

- Retiree Only Retiree plus Spouse
- Retiree plus Child(ren) Family

Dental Coverage – Delta Dental

Change Cancel (*cannot be reinstated*)

Level of Coverage (Select Only One)

- Retiree Only
- Retiree plus Spouse
- Retiree plus Child(ren)
- Family

For Office Use Only

- VRS
- ACERS
- Direct Payment

Spouse/Dependent Information – Enter spouse/dependent to be dropped from coverage

Social Security No.	Name (First, MI, Last)	Relationship	Date of Birth	Medical Y/N	Dental Y/N	Drop

I hereby request the above change and guarantee payment of the required contributions for the above elected plan(s) through either pension deduction or direct payment to APS. If I elect to cancel coverage through Arlington Public Schools, I will not be allowed to enroll on a later date and my coverage cannot be reinstated.

Employee Signature: _____ Date: _____

Return completed/signed form to:

Arlington Public Schools, Human Resources Department 2110 Washington Blvd., 4th Fl., Arlington, VA 22204 Fax: 703-841-2138