Arlington Public Schools
Retiree Benefits Change Form

Retiree Name (Last, First, MI) _____

SSN #: _____ Medicare Eligible: Yes _____ No_____

Life Event (Select Only One)

Effective Date: **01/01/2026**

☐ 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

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