Retiree Open Enrollment 2025

Forms Kit

For Medicare-Eligible Participants

In this Kit

- **City of Alexandria Retiree Medical Plan Change Form**
  - You **DO NOT NEED TO RETURN ANY FORMS** if you are not making any changes!
  - Return this form only if you are making changes to your coverage
- **City of Alexandria Retiree Information Form**
  - Return this form only you are changing your demographic information
- **City of Alexandria Retiree Medical Insurance Reimbursement Statement and Reimbursement Program Information**
  - Return this form only if you require reimbursements for the cost of your Retiree Medical premium payments
- **The Standard Retiree Benefit Change Form**
  - Return this form if you are changing your beneficiary or demographic information for your retiree coverage with The Standard

Forms are due by November 29th!

You have several options to submit your change forms:

- **REGULAR MAIL:** Must be postmarked by November 29
- **DROP-OFF TO HR DEPARTMENT:** Must be returned by 5 PM ET on November 29
- **FAX**: Must be returned by 5 PM ET on November 29
- **E-MAIL:** Must be timestamped by 5 PM ET on November 29

Address: 301 King Street, Suite 2500, 2nd Floor Alexandria, VA 22314
Fax: 703.838.3850
Email: DHR.Benefits@alexandriava.gov

Human Resources Department

2025 RETIREE MEDICAL PLAN CHANGE FORM

RETIREES WHO DO NOT WISH TO MAKE ANY CHANGES
DO NOT NEED TO COMPLETE AND SUBMIT THIS FORM.
COMPLETE AND RETURN THIS FORM (by mail or fax) BY **NOVEMBER 29, 2024** ONLY IF YOU WISH TO SELECT A DIFFERENT MEDICAL PLAN effective **JANUARY 1, 2025**

HEALTHCARE PLAN SELECTION

Kaiser Permanente Medicare Plan: ____

UnitedHealthcare Medicare Advantage PPO Plan: ____

Insurance Reimbursement Plan: ____

No change in Health Option: _____

COVERAGE LEVEL SELECTION

_____ Individual _____ Retiree + Spouse _____ Retiree + Child(ren) _____ Family

Names of other family members to be added or dropped: Circle one.

Drop/ Add _____ Date of Birth _____

Drop/ Add _____ Date of Birth _____

VITAL SAVINGS PROGRAM ELECTION

Enrollment in Aetna Vital Savings Program: _____ Delete Aetna Vital Savings Program: _____

COVERAGE LEVEL SELECTION

_____ Individual Coverage ($2.20/mo.) _____ Retiree + 1 or more Coverage ($3.75/mo.)

_____ Print Name

_____ Date

_____ Signature

_____ Phone

_____ Email

_____ Date of Birth

City of Alexandria, Human Resources Department: Benefits Team
Address: 301 King Street, Suite 2500, 2nd Floor Alexandria, VA 22314, Fax: 703.838.3850
EMAIL questions to: DHR.Benefits@alexandriava.gov

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City of Alexandria
Retiree Information Form

Retiree Name		
Retirement Date	Department Retired from	Sworn staff? Yes ☐ No ☐
SSN	Comments:	

Retiree Information

Current Address: Street			Home Phone
City	State	Zip code	Cell Phone
Date of Birth	Gender	Marital Status	Email

Spouse Information (if Applicable)

Spouse Name			
Current Address: Street		Same as above ☐	Home Phone
City	State	Zip code	Work/Cell Phone
Date of Birth	Gender	SSN	

Emergency Contact Information

Contact Name			
Address: Street			Phone
City	State	Zip code	Relation

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HUMAN RESOURCES DEPARTMENT

301 King Street, Suite 2510
Alexandria, Virginia 22314-1500
Phone (703)746-3777
Fax (703) 838-3850

RETIREE MEDICAL INSURANCE REIMBURSEMENT STATEMENT

NAME OF RETIREE _____
(PLEASE PRINT)

DATE OF BIRTH _____

ADDRESS _____

TELEPHONE _____

EMAIL ADDRESS _____

Insurance Plan Name: _____ **Spouse Plan? Yes** ___ **No** ___

Plan Year (Month/Year): _____

If the coverage is in your spouse's name, please be sure to provide the rate for both individual and family premiums. This information is required to determine the cost of adding you to your spouse's plan only.

Monthly premiums: Individual $_____ **Family: $**_____ **Other:** _____

Proof of coverage attached (please check all that apply):

_____**Statement of monthly premiums from plan carrier or employer.**

_____**Copies of payment coupons and cancelled checks.**

_____**Copies of payroll check stubs reflecting payroll deductions for health insurance coverage.**

I request to be reimbursed for the cost of healthcare premiums I have paid as shown above. I understand that I must notify the Human Resources Department immediately if my premiums change or if I am no longer qualified for this program.

Date _____ **Signature** _____

CITY OF ALEXANDRIA RETIREE HEALTH INSURANCE REIMBURSEMENT PROGRAM

QUESTION AND ANSWER SUMMARY
OCTOBER 2024

This Question-and-Answer Summary has been prepared to explain the current eligibility provisions and administrative provisions for the reimbursement program. The City reserves the right to amend or terminate any provision of this program.

Q. <u>Who is eligible to participate in the reimbursement program?</u>

A. Retirees that were enrolled in a City sponsored health plan on their date of retirement and

1. are receiving lifetime monthly benefits from a primary City retirement plan, or

2. are Retired Police Officers and Firefighters participating in the defined contribution retirement income plan with at least *20 years* of City service, or

3. Employees who retired with disability benefits from a primary City retirement plan.

Q. <u>Are former employees who are vested in the retirement plan and leave City service eligible to participate when they apply for a retirement benefit in the future?</u>

A. No. Only those employees who retired with immediate benefits from City service and were enrolled in a City sponsored health plan at retirement may participate.

Q. <u>How much is the monthly reimbursement amount?</u>

A. Reimbursement is based upon the retiree's date of hire and years of service with the City. Based on this information, the retiree is eligible for a monthly insurance premium UP TO $260.00* per month.
***If you HAVE UNDER 25 YEARS OF SERVICE WITH THE CITY and WERE HIRED AFTER JULY 1, 2008, please see page 6 of the Retiree Insurance Program Handbook for your eligible health supplement amount.**

Q. <u>How does a retiree actively participate?</u>

A. Eligible retirees must complete the blue *Reimbursement Statement and furnish proof of health insurance coverage*/payments annually before the start of their new plan year.

Q. <u>How often are reimbursement payments made?</u>

A. Reimbursements are made via Electronic Funds Transfer (EFT) on the 15th of every month. If it is a weekend or holiday, it will be the next business day.

Proof of premium increases must be made by program participants 60 days before the effective date of the change. The remaining months will be paid automatically with no further documentation from you. **Retroactive payments cannot be made for prior quarters.**

Q. <u>What is needed as proof of coverage and payments for reimbursement?</u>

A. Proof of insurance coverage can be any of the following:

1. A statement from the insurance plan carrier or employer which shows the type of coverage (individual or family) and the retiree's monthly <u>cost</u> for such coverage, or

2. Receipts or other copies of payment made along with a copy of canceled checks, or

3. Copies of paycheck stubs for the period showing the deductions were paid along with a copy of the employer's verification of health plan and type of coverage.

If the retiree is covered under a spouse's insurance plan, then the monthly rates for both the spouse's individual <u>and</u> employee plus one or family coverage must be provided. An example appears below**.

Q. **Will reimbursement be made if a spouse adds the qualified City retiree to his/her employer's plan?

A. Yes. Reimbursement is based on the difference between the spouse's cost for an individual plan and the spouse's cost for converting to an employee plus one or family plan. For example, the spouse's coverage as an individual is $140 per month. The spouse's cost, including family members is $300 per month. In this case, the City will reimburse the difference between $300 and $140 or $160 per month ***provided you are eligible for**

reimbursement of $160 based on Page 6 of the Retiree Insurance Program Handbook for your eligible health supplement amount.

Q. When is the proof needed to ensure timely payment?

A. The City must receive the proof needed 60 days before the start of your plan year and 60 days prior to any premium change.

Q. Will the City reimburse for more than one health plan?

A. No. The City will only provide reimbursement for a single basic health plan which provides hospital and physician care. A health plan with a wraparound prescription plan is considered a single plan. Medicare premiums will be considered for reimbursement only if the retiree does not participate in any other health insurance plan.

Q. **Are dental and vision care plans included in the program?**

A. Only if the coverage is already included as part of the basic health insurance plan.

Q. If the retiree's monthly cost for health coverage is less than $260.00 then what will the retiree be eligible to receive?

A. If the retiree's monthly cost is less than the monthly eligible health supplement on ***page 6 of the Retiree Insurance Program Handbook**, then the ***actual cost*** of health insurance premiums.

Q. If the retiree dies, does the spouse become eligible for the reimbursement program?

A. Only if the spouse and eligible dependents were covered under the retiree's health insurance plan. Contact the Benefits Team for more information.

Q. Where do I send my request to participate and the necessary documentation?

A. Send the Reimbursement Statement along with proof of coverage or payment to Human Resources Services Department,
Benefits Division, P.O. Box 178, 301 King Street Alexandria, VA 22314.

Q. What if I have questions that are not discussed here?
A. Contact the Benefits Team.

Revised 10/14/2024

Standard Insurance Company

Change Form - Retirees

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)		Group Name **City of Alexandria**	Group Number(s) **645212**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Date Retired	

LIFE

Life Insurance

☒ Amount in effect as of your date of retirement.

BENEFICIARY

This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	**Address**	**Soc. Sec. No.**	**Relationship**	**% of Benefit**

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change ☐ Beneficiary Change

Former name _____

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Human Resources Department - Complete this section. Retain form for your records.

Received by	Date

Beneficiary Information

- Your designation revokes all prior designations.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

- If you name two or more Beneficiaries in a class:

    1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

    2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

    3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____ ."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.