



**Early- Retiree  
Open Enrollment  
FY 2027  
Forms Kit**

For Early Retiree Participants

# In this Kit

- **City of Alexandria Early Retiree Plan Change Form**
  - You **DO NOT NEED TO RETURN ANY FORMS** if you are not making any changes!
  - Note, there are some rate changes per the Memo
- **City of Alexandria Retiree Information Form**
  - Return this form only you are changing your demographic information
- **City of Alexandria Retiree Medical Insurance Reimbursement Statement**
  - Return this form only if you require reimbursements for the cost of your Retiree Medical premium payments
- **City of Alexandria Retiree EFT Authorization Agreement**
  - Return this form if you are changing your bank account information or are requesting Electronic Funds Transfer (EFT) for the first time
- **The Standard Retiree Benefit Change Form**
  - Return this form if you are changing your beneficiary or demographic information for your retiree life insurance coverage with The Standard

**Forms are due by May 22, 2026!**

**You have several options to submit your change forms:**

- **REGULAR MAIL:** Must be postmarked by May 22, 2026 (note new address below!)
- **DROP-OFF TO HR DEPARTMENT:** Must be returned by 5 PM ET on May 22, 2026 (note new address!)
- **E-MAIL:** Must be timestamped by 5 PM ET on May 22, 2026

**Address:** 2331 Mill Road, Room 301, Alexandria, VA 22314

**Email:** [DHR.Benefits@alexandriava.gov](mailto:DHR.Benefits@alexandriava.gov)



Department of Human Resources  
**FY2027 EARLY RETIREE PLAN CHANGE FORM**

RETIREEES WHO **DO NOT** WISH TO MAKE ANY CHANGES FOR FY 2027 **DO NOT** NEED TO COMPLETE THIS FORM. THIS FORM IS TO BE COMPLETED AND RETURNED/POSTMARKED BY **MAY 22, 2026**, ONLY BY THOSE RETIREEES WHO WISH TO MAKE A CHANGE TO THEIR PLAN AND/OR COVERAGE LEVEL. CHANGES WILL BE EFFECTIVE JULY 1, 2026.

Directions: Place an "X" on the lines below for the medical, dental, and vision plan(s) and the coverage level you would like for **FY 2027**. Then complete page 2 and sign. This form can be submitted by email or mailed to the address listed below.

Retiree name (please print) \_\_\_\_\_

**MEDICAL PLAN SELECTION**

**Kaiser Permanente:** \_\_\_\_\_DHMO \_\_\_\_\_HMO\* \_\_\_\_\_CDHP

\*HMO plan is open to current enrollees only—new enrollments not permitted

**United Healthcare:** \_\_\_\_\_Choice \_\_\_\_\_Choice Plus \_\_\_\_\_CDHP

**City of Alexandria:** \_\_\_\_\_Insurance Reimbursement Plan\*

\*Must also complete and return the Retiree Medical Insurance Reimbursement Plan form

**COVERAGE LEVEL SELECTION**

\_\_\_\_\_Individual \_\_\_\_\_Retiree + Spouse \_\_\_\_\_Retiree + Child(ren) \_\_\_\_\_Family

**DENTAL PLAN SELECTION**

**Aetna:** \_\_\_\_\_DMO \_\_\_\_\_PPO

**COVERAGE LEVEL SELECTION**

\_\_\_\_\_Individual \_\_\_\_\_Retiree + Spouse \_\_\_\_\_Retiree + Child(ren) \_\_\_\_\_Family  
\_\_\_\_\_None--I do not want dental coverage.

**VISION PLAN SELECTION**

**Aetna:** \_\_\_\_\_Vision Plan

**COVERAGE LEVEL SELECTION**

\_\_\_\_\_Individual \_\_\_\_\_Retiree + Spouse \_\_\_\_\_Retiree + Child(ren) \_\_\_\_\_Family  
\_\_\_\_\_None--I do not want vision coverage. **(OVER)**

**Family members to be added or removed from health, dental, or vision insurance coverage:**

Add/Remove (Circle one)	Name	Date of Birth (MM/DD/YYYY)	Relationship
Add/Remove			
Add/Remove			
Add/Remove			

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**SUPPLEMENTAL LIFE INSURANCE**

Place an "X" on the line below ONLY if you want to terminate your supplemental life insurance coverage. **If you want to keep your current coverage, no action is necessary.**

\_\_\_\_\_ I hereby terminate my supplemental life insurance. I understand that this decision is final and I will not be able to re-enroll in supplemental life insurance coverage. I also understand that Basic (City-paid) life insurance I have will remain in force, subject to applicable age reductions.

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**COMPLETE AND SIGN**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email address

**RETURN TO:**

Department of Human Resources, ATTN: Benefits  
**By mail:** 2331 Mill Road, Room 301, Alexandria, VA 22314  
**By email:** [DHR.Benefits@alexandriava.gov](mailto:DHR.Benefits@alexandriava.gov)

**City of Alexandria  
Retiree Information Form**



Retiree Name		
Retirement Date	Department Retired from	Sworn staff? Yes <input type="checkbox"/> No <input type="checkbox"/>
SSN	Email Address:	

**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 <input type="checkbox"/>	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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**DEPARTMENT OF HUMAN RESOURCES**

2331 Mill Road, Room 301  
Alexandria, Virginia 22314  
Phone: 703.746.3777

**RETIREE MEDICAL INSURANCE REIMBURSEMENT PLAN**

**NAME OF RETIREE** \_\_\_\_\_  
(PLEASE PRINT)

**DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**TELEPHONE Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**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 Department of Human Resources immediately if my premiums change or if I am no longer qualified for this program.

**Date** \_\_\_\_\_

**Signature** \_\_\_\_\_

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**CITY OF ALEXANDRIA  
DEPARTMENT OF HUMAN RESOURCES**

2331 Mill Road, Room 301  
Alexandria, VA 22314

Phone: 703-746-3777  
www.alexandriava.gov

**Authorization Agreement for Electronic Funds Transfer for  
Retiree Health and/or Life Insurance Premium Payments**

I authorize the City of Alexandria, through Truist, to automatically debit/credit my bank account for health and/or life insurance payments/reimbursements as specified below. I understand that transactions will be processed on the 15th of each month. If the 15th falls on a holiday or weekend, transactions will be processed the next business day. I understand that funds will not be transferred to the City if there are insufficient funds in my account and that I will be subject to a \$35 returned check fee.

Complete this agreement and attach a voided check from your checking account. A deposit slip may be used for a savings account only. Mail the completed agreement and your voided check to: Department of Human Resources, ATTN: Benefits, 2331 Mill Road, Room 301, Alexandria, VA 22314.

**Applicant's Name:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_ SSN: \_\_\_\_\_

**Mailing Address:**

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Email:** \_\_\_\_\_

**Telephone Number:** Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**Bank Name:** \_\_\_\_\_  Checking  Savings

**Name of Account Holder:** \_\_\_\_\_

**Bank Routing Number (nine digits):** \_\_\_\_\_ **Bank Account Number:** \_\_\_\_\_

By signing this agreement I understand I am authorizing the City to automatically debit/credit my bank account for health, dental, vision and/or life insurance payments/reimbursements and to stop health and/or life insurance deductions from my monthly VRS and/or Empower retirement payments, if applicable. I also understand that this electronic funds transfer authorization remains in effect until the City of Alexandria receives written notification of its termination. Written cancellation must be received by the City at least 15 days before the next scheduled deduction.

I have read and agree to the terms and conditions contained in this Authorization Agreement.

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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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 <b>City of Alexandria</b>		Group Number(s) <b>645212</b>	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Date Retired	
LIFE	<b>Life Insurance</b> <input checked="" type="checkbox"/> Amount in effect as of your date of retirement.					
BENEFICIARY	<i>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.</i>					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Name Change <span style="margin-left: 200px;"><input type="checkbox"/> Beneficiary Change</span> 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)	
<b>Human Resources Department - Complete this section. Retain form for your records.</b>						
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.