ORANGE COUNTY PUBLIC SCHOOLS
2023-2024 RETIREES INSURANCE ENROLLMENT/CHANGE FORM

❑ New Retiree ❑ Change Only

Office Use Only:
Effective Date_____

Please Print

Last Name	First Name	MI	Social Security #

Mailing Address	City	State	Zip

Birth Date (month/day/year)	Home Telephone Number	Date Of Retirement
	( )	

INSURANCE OPTIONS

NEW RETIREES

If you are a **NEW** retiree, please follow these directions:

1. Check the boxes in the I WANT TO ADD column for the options you had as an employee before you retired. It is necessary to remain with your current plan until the time of annual enrollment.
2. If you currently have retiree medical coverage and you want to add your spouse/same-sex domestic partner and/or children, it is necessary to enroll during a special or annual enrollment.

CURRENT RETIREES

If you are a **CURRENT RETIREE** wanting to make a change, please follow these directions:

1. Check the boxes in the I WANT TO ADD column for the options you want to add.
2. Check the boxes in the I WANT TO DROP column for the options you want to drop.

Please call TASC Customer Service at 1-800-422-4661 if you need to obtain and complete one of the forms below. The following rates are effective 10/01/2023.

IF YOU SELECT ANY DEPENDENT COVERAGE FOR THE FOLLOWING MEDICAL OR DENTAL COVERAGES, PLEASE COMPLETE THE DEPENDENT INFORMATION SECTION AT THE BOTTOM OF THE FOLLOWING PAGE.

I. MEDICAL INSURANCE

Please select one:	I WANT TO ADD (Monthly Rate) CIGNA Local Plus OAP In-Network	CIGNA Health Reimbursement Account (HRA)	CIGNA OAP In-Network	CIGNA SureFit	I WANT TO DROP CIGNA LocalPlus OAP In-Network	CIGNA Health Reimbursement Account (HRA)	CIGNA OAP In-Network	CIGNA SureFit
Retiree	❑ $774.05	❑ $817.83	❑ $817.83	❑ $774.05	❑	❑	❑	❑
Retiree + Children	❑ $832.77	❑ $1,482.68	❑ $1,208.83	❑ $815.72	❑	❑	❑	❑
Retiree + Spouse/Same-Sex Domestic Partner	❑ $1,067.58	❑ $1,760.47	❑ $1,462.57	❑ $1,067.58	❑	❑	❑	❑
Retiree+Children+Spouse/ Same-Sex Domestic Partner	❑ $1,126.30	❑ $2,019.63	❑ $1,699.27	❑ $1,107.38	❑	❑	❑	❑
Spouse/Same-Sex Domestic Partner*	❑ $774.05	❑ $817.83	❑ $817.83	❑ $774.05	❑	❑	❑	❑
Spouse/Same-Sex Domestic Partner + Children*	❑ $832.77	❑ $1,482.68	❑ $1,208.83	❑ $815.72	❑	❑	❑	❑
Children Only*	❑ $352.25	❑ $664.85	❑ $664.85	❑ $333.33	❑	❑	❑	❑

*When retiree is enrolled in an FSRBC plan.

If you are applying for a disability retirement, please do not complete the following section. Instead, call the Insurance Benefits Section at 407.317.3245 for information regarding continuation of your life insurance.

II. TERM LIFE INSURANCE

Please select one:	(Monthly Rate) I WANT TO ADD	I WANT TO DROP
$1,000	❑ $4.09	❑
$5,000 (health questions required)	❑ $20.45	❑
$10,000 (health questions required)	❑ $40.90	❑

BENEFICIARY INFORMATION

Please complete the following information:	Complete Name	Relationship
Primary:		
Contingent:		
Contingent:		

III. GROUP UNIVERSAL LIFE (GUL)

You may continue additional life insurance coverage for yourself, your spouse/domestic partner and your eligible dependent children. You and your spouse/domestic partner also have the ability to make contributions to a cash accumulation fund. Please refer to the **Group Universal Life** section of the *OCPS Retiree Handbook*

IV. DENTAL INSURANCE

Dental Facility # _____

	I WANT TO ADD (Monthly Rate) DeltaCare BASIC	DeltaCare COMPREHENSIVE	DeltaDental PPO	I WANT TO DROP DeltaCare BASIC	DeltaCare COMPREHENSIVE	DeltaDental PPO
Retiree Only	❑ $10.40	❑ $17.00	❑ $37.05	❑	❑	❑
Retiree + 1 Dependent	❑ $17.18	❑ $31.80	❑ $63.61	❑	❑	❑
Retiree + 2 or More Dependents	❑ $25.38	❑ $38.93	❑ $90.98	❑	❑	❑

V. VISION CARE

	I WANT TO ADD (Monthly Rate) Humana Specialty Benefits Vision Plan	I WANT TO DROP Humana Specialty Benefits Vision Plan
Retiree Only	❑ $5.52	❑
Retiree + dependents	❑ $15.32	❑

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of obtaining a benefit that the retiree, spouse and/or dependent would not otherwise be entitled. In signing this form you (OCPS retiree) confirm that the information contained herein (including dependent information) is accurate to the best of your knowledge. Further you acknowledge that it is your responsibility to notify the Plan of any changes to dependent (spouse/domestic partner and /or children) eligibility. **Should you knowingly provide false, incomplete or misleading information OCPS will seek recovery of all applicable premiums and paid claims and report you to the appropriate agencies.**

DEPENDENT INFORMATION

Dependent	Relationship	Medical	Dental	Vision	Social Security No.	Date Of Birth
		❑	❑	❑		
		❑	❑	❑		
		❑	❑	❑		
		❑	❑	❑		

I will pay for the coverage I have selected above via monthly FRS pension check deductions or by monthly premium coupons to be sent to me by ***TASC.***

Retiree Signature _____ Date Signed _____