Enrollment Form 2016-17

The Local Choice Health Benefits Program

The Local Choice Health Benefits Program (TLC) offers health care coverage to local school divisions and government jurisdictions. It is managed by the Virginia Department of Human Resource Management (DHRM), which also oversees the State Health Benefits Program. For more information, visit www.thelocalchoice.virginia.gov or contact your Benefits Administrator.

When can I request enrollment or election changes?

TLC uses the most liberal eligibility and enrollment rules allowed by IRS and this form describes in general terms who is eligible for and may enroll in TLC health care plans. If your employer has a plan document with more restrictive rules, you must comply with that document. Be sure to contact your Benefits Administrator for your employer's specific plan rules.

- Initial Enrollment:

  - As Employee: Your request to enroll must be received within 30 days of when you begin employment or become newly eligible for coverage. When your request is received by the deadline, your coverage takes effect the first of the month coinciding with or following the date of employment or the completion of any waiting period. If you miss the deadline, you must wait for Open Enrollment or another qualifying mid-year event, whichever comes first.

  - As Retiree: Your request to enroll must be received within 31 days of when you retire. When your request is received by the deadline, your coverage takes effect the day after your employee coverage ends.

  - As Survivor of a Retiree: TLC requires that your request to enroll be received within 60 days of the death. If your employer's plan document calls for a more restrictive timeframe, you must comply with that document. When your request is received by the deadline, your coverage takes effect the first of the month coinciding with or following the death.

  - As Extended Coverage/COBRA Qualified Beneficiary: Your initial request to enroll must be submitted on the Election Form provided in your Election Notice. Your Election Notice also includes information about your Extended Coverage/COBRA rights and responsibilities. Qualified beneficiaries enrolled in TLC Extended Coverage/COBRA have available to them the same coverage and the same opportunities to make changes in their coverage as those who are not receiving Extended Coverage/COBRA.

- Open Enrollment: Open Enrollment occurs each year and is announced by your employer. It is your annual opportunity to request enrollment or make election changes. Contact your Benefits Administrator with specific questions.

- Qualifying Mid-Year Event: With supporting documentation, certain events during the plan year permit enrollment or election changes. TLC requires that your request be received within 60 days of the event. If your employer's plan document calls for a more restrictive timeframe, you must comply with that document. Your request must also be consistent with the event. For example, divorce is consistent with removing a spouse; marriage is consistent with adding a spouse; and birth is consistent with adding a child. Coverage begins on the first day and ends on the last day of a month. When your request is received by the deadline, coverage takes effect the first of the month after your request is received or after the event, whichever is later. When the later date is the first of a month, coverage is effective that day. In the case of birth or adoption, coverage takes effect on the first day of the month in which the child is born, adopted or placed for adoption. If you miss the 60-day deadline, you must wait for Open Enrollment or another qualifying mid-year event, whichever comes first. Other events may permit limited enrollment or election changes. Your Benefits Administrator can help with specific questions.

  For Retirees, Survivors, and Extended Coverage/COBRA Qualified Beneficiaries: You may request to remove family members prospectively by completing the attached enrollment form. The change becomes effective the first of the month after your request is received. If you want to cancel coverage for yourself and all covered persons, stop paying the total premium and coverage will cease at the end of the payment grace period. Contact your Benefits Administrator with specific questions.

How can I request enrollment or election changes?

Complete and return the attached enrollment form with supporting documentation to your Benefits Administrator within the required timeframe. Contact your Benefits Administrator before a deadline if you have questions or need more time to submit supporting documentation.

The Local Choice Health Benefits Program Enrollment Form

PART 1: CERTIFICATION AND AUTHORIZATION OF THE PERSON SUBMITTING THIS ELECTION REQUEST

Review, complete, and submit this enrollment form with supporting documentation to your Benefits Administrator within the required timeframe. If you have questions or need more time, contact your Benefits Administrator before the deadline. Please print clearly. This form must be signed by the employee, retiree, survivor or Extended Coverage/COBRA qualified beneficiary. Forms signed by a family member will not be accepted.

Health Plan ID or Social Security Number: _____

First Name: _____ Middle Initial: _____ Last Name, Suffix (Jr, Sr, II, III): _____

☐I certify that I have reviewed the instructions on this enrollment form and that the information submitted is complete and accurate to the best of my knowledge. I understand that once this election goes into effect, it may not be changed without a subsequent qualifying mid-year event or until the next Open Enrollment. I also understand that The Local Choice Health Benefits Program and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Signature: _____ Date (MM/DD/YY): ___/___/___

☐Full-time Employee ☐Part-time Employee ☐Retiree ☐Survivor of Retiree ☐Extended Coverage/COBRA Qualified Beneficiary

PART 2: REASON FOR SUBMITTING THIS ELECTION REQUEST And REQUIRED SUPPORTING DOCUMENTATION

A. ☐ Initial Enrollment as Employee Hire Date (MM/DD/YY): ___/___/___

B. ☐ Initial Enrollment as Early Retiree Last Day of prior coverage (MM/DD/YY): ___/___/___

C. ☐ Initial Enrollment as Medicare Retiree Last Day of prior coverage (MM/DD/YY): ___/___/___

D. ☐ Initial Enrollment as Survivor of Retiree ☐Spouse ☐Child Deceased's Date of Death (MM/DD/YY): ___/___/___

Deceased's Name: _____ Deceased's Health Plan ID: _____

E. ☐ Initial Enrollment as Extended Coverage/COBRA Qualified Beneficiary Last Day of prior coverage (MM/DD/YY): ___/___/___

F. ☐ Open Enrollment

G. ☐ Qualifying Mid-Year Event (indicate the event below) Qualifying Mid-Year Event Date (MM/DD/YY): ___/___/___

Events consistent with adding family members to coverage:

- ☐Marriage (marriage certificate)
- ☐Birth or Adoption (birth certificate or adoption agreement)
- ☐Judgment, decree, or other order(including permanent custody) to add an eligible child (court order)
- ☐Eligible family member lost eligibility under governmental plan (government documentation)
- ☐Eligible family member lost eligibility for Medicare or Medicaid (government documentation)
- ☐Eligible family member lost eligibility under their employers plan (employer documentation)
- ☐HIPAA special enrollment due to loss of other group coverage (HIPAA certificate)

Events consistent with removing family members from coverage:

- ☐Divorce (divorce decree)
- ☐Death of spouse (documentation validating death)
- ☐Death of covered child (documentation validating death)
- ☐Covered child lost eligibility under this health plan (loss of coverage documentation)
- ☐Judgment, decree or order to remove a covered child (court order)
- ☐Covered family member now eligible for Medicare or Medicaid (Medicare or Medicaid documentation)
- ☐Covered family member now eligible under their employer's plan (employer documentation)

Other Events validated by your Benefits Administrator:

- Employment Change: ☐Full-time to Part-time ☐Part-time to Full-time ☐Unpaid Leave Began ☐Unpaid Leave Ended
- ☐Significant change or Open Enrollment under the other employer's plan (employer documentation)
- ☐Move affecting eligibility for this health plan
- ☐Eligible participant waived own coverage to be added as family member under this plan
- ☐Enrollment in a Marketplace Exchange health plan (documentation of coverage with the effective date)
- ☐Other Event not listed on this form: _____

H. ☐ Extend the length of Extended Coverage/COBRA (indicate the reason below): Event Date (MM/DD/YY): ___/___/___

- ☐Death of former employee (documentation validating death)
- ☐Divorce from former employee (divorce decree)
- ☐Covered child loses eligibility under the Plan (loss of coverage documentation)
- ☐Social Security Approved Disability (approval documentation) Approval Date (MM/DD/YY): ___/___/___

PART 3: IDENTIFICATION OF THE PERSON SUBMITTING THIS ELECTION REQUEST

Health Plan ID or Social Security Number: _____ Date of Birth (MM/DD/YYYY): ___/___/___

First Name: _____ Middle Initial: _____ Last Name, Suffix (Jr, Sr, II, III): _____

Street or PO Box: _____

City: _____ State: _____ Zip+4: _____-_____ ☐Female ☐Male

Work Phone (999) 999-9999: (___) ___-_____ Personal Phone (999) 999-9999: (___) ___-_____

Email: _____

☐Full-time Employee ☐Part-time Employee ☐Retiree ☐Survivor of Retiree ☐Extended Coverage/COBRA Qualified Beneficiary

PART 4: HEALTH CARE COVERAGE ELECTION REQUEST

A. ☐ I want to waive enrollment in this health care coverage at this time. Indicate below if you have other health care coverage.

☐I am enrolled in other health care coverage. Other coverage ID Number: _____

Plan Administrator: _____ Policy Holder's Name: _____

☐ I am not covered by any other health care coverage.

B. Indicate your plan selection and the person(s) to be covered by this selection. Do not list a person you want removed from coverage.

☐KA Expanded-Comprehensive ☐KA 500-Comprehensive ☐High Deductible Plan-Comprehensive
☐KA Expanded-Preventive ☐KA 500-Preventive ☐High Deductible Plan-Preventive
☐KA 250-Comprehensive ☐KA 1000-Comprehensive ☐Kaiser HMO
☐KA 250-Preventive ☐KA 1000-Preventive

IMPORTANT: List each person, including yourself, that you want covered by this plan - include a code for each person.
Codes: M=Myself; SM=Male Spouse; SF=Female Spouse; D=Daughter; S=Son; SD-Stepdaughter; SS=Stepson; O=Other Approved Child

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Sex (F/M)	Date of Birth (MM/DD/YY)	Social Security Number (999-99-9999)
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -

C. Indicate your Medicare-coordinating plan selection and the person(s) to be covered by this selection – include a code for each person.

☐Advantage 65 ☐Advantage 65 + Dental & Vision ☐Option I: Medicare Complimentary

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Sex (F/M)	Date of Birth (MM/DD/YY)	Social Security Number (999-99-9999)
					/ /	- -
Medicare ID:		Part A (MM/DD/YY): / /			Part B (MM/DD/YY):	/ /
					/ /	- -
Medicare ID:		Part A (MM/DD/YY): / /			Part B (MM/DD/YY):	/ /

PART 5: CERTIFICATION AND AUTHORIZATION OF THE BENEFITS ADMINISTRATOR FOR THIS ELECTION

Form Received (MM/DD/YY): ___/___/___ Effective Date (MM/DD/YY): ___/___/___ ☐Group Bill ☐Direct Bill

Extended Coverage/COBRA ends (MM/DD/YY): ___/___/___ DHRM Group No: _____-_____

☐I certify that the information on this form and in the required supporting documentation is complete and accurate to the best of my knowledge.

Authorized by: Name: _____ Phone (999) 999-9999: (___) ___-_____ Ext: _____

Send authorized form by: Email: TLC@dhrm.virginia.gov, Fax: (804) 786-1708, or Mail: DHRM-TLC, 101 N 14th St Fl 13, Richmond, VA 23219