

Employer Data Sheet

Return this Data Sheet to

The Local Choice Health Benefits Program
 Commonwealth of Virginia
 Department of Human Resource Management
 101 North 14th Street - 13th Floor
 Richmond, VA 23219
 Phone (804) 786.6460 · Fax (804) 786.1708



Government Group Number: 047 - _____

School Group Number: 048 - _____

Please make sure you answer each question and fill in all blanks. Then print, sign and return this form to the address shown above.

You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan.

1. Group Name: _____

2 **New Group: Effective Date:** _____ **Renewal: July** **Renewal: October**

3 **Government Group** **School Group** **Combined Government & School Group**
 (An Employer Data Sheet required for each.)

4. Indicate each category of enrollees offered coverage by this group.

Category of Enrollees	Minimum Hours Per Week	Number Waived	Number Enrolled	Number Eligible (Number Waived plus Number Enrolled)	Percentage (Number Enrolled divided by Number Eligible)
<input type="checkbox"/> Full-time Employees*					NA
<input type="checkbox"/> Full-time Elected Officials					NA
<input type="checkbox"/> Part-time Employees**					NA
<input type="checkbox"/> Part-time Elected Officials					NA
Total Full-time & Part-time Employees					
<input type="checkbox"/> Yes <input type="checkbox"/> No Extra month for survivors: An extra month of continued coverage for survivors of deceased enrollees is available. If selected, survivors must participate, the full premium with employer and employee contributions is required, and no plan change is permitted.					

* Group's Definition of Full-time Employee: _____

** Group's Definition of Part-time Employee: _____

Category of Enrollees	Number Enrolled	Direct Bill?
<input type="checkbox"/> COBRA Qualified Beneficiaries***		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Early Retirees (Not Eligible for Medicare)		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medicare Retirees (Eligible for Medicare)		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Survivors of Retiree		<input type="checkbox"/> Yes <input type="checkbox"/> No

*** Employers with fewer than 20 employees on a typical business day during the preceding calendar year are not allowed to offer COBRA. This exclusion is based on the actual number of full-time and part-time employees rather than number enrolled.

Does this group require SubGroups? Yes No (If yes, list the subgroups below and complete Page 6 for each SubGroup.)

Sub-Group Name: _____ Sub-group Number: _____
 Sub-Group Name: _____ Sub-group Number: _____

5. Does this group have a Section 125 Pre-tax plan? Yes No

This form describes in general terms when enrollment or election changes may be made under TLC rules. An employer group with a Section 125 pre-tax plan may have stricter rules.

6. Initial Enrollment: Does this group have stricter enrollment rules than TLC? Yes No

For Employees: Requests must be received within 30 days of when one begins employment or becomes newly eligible for coverage. Coverage begins on the first day of a month and ends on the last day of a month. When the request is received by the deadline, coverage takes effect the first of the month coinciding with or following the date of employment. If the 30-day deadline is missed, one must wait for Open Enrollment or another Qualifying Mid-Year Event whichever comes first.

For Retirees: Requests must be received within 31 days of when retirement begins. Coverage begins on the first day of a month and ends on the last day of a month. When the request is received by the deadline, coverage takes effect the day after the employee coverage ended.

For Survivors of Retiree: Requests must be received within 60 days of the death. Coverage begins on the first day of a month and ends on the last day of a month. When the request is received by the deadline, coverage takes effect the first of the month coinciding with or following the death.

For COBRA Qualified Beneficiaries: Requests must be submitted on the Election Form provided in the Election Notice and received within 60 days after the loss of coverage or 60 days from the date of the Election Notice, whichever is later. Coverage begins on the first day of a month and ends on the last day of a month. When the request is received by the deadline, coverage takes effect the day after the prior coverage ended.

7. Open Enrollment: When is Open Enrollment held for this group?

Month: _____ **Day:** _____ **through Month:** _____ **Day:** _____

TLC requires an Open Enrollment period **no longer than 30 days between April 1 and May 15 for groups effective 7/1 and between July 28 and September 10 for groups effective 10/1.**

8. Qualifying Mid-Year Events: Does this group have stricter enrollment rules than TLC? Yes No

TLC permits enrollment or election changes with supporting documentation during the plan year for certain Qualifying Mid-year Events. The request must be received within 60 days of the event and be consistent with the event. For example, divorce would be consistent with removing a spouse; marriage would be consistent with adding a spouse; and birth would be consistent with adding a child. Coverage begins on the first day of a month and ends on the last day of a month. When the request is received by the deadline, coverage takes effect the first of the month after the request is received or after the event, whichever is later. When the later date is the first of the month, coverage is effective that day. In the case of birth or adoption, coverage takes effect on the first of the month in which the child is born, adopted, or placed for adoption. If the 60-day deadline is missed, one must wait for Open Enrollment or another Qualifying Mid-Year Event, whichever comes first.

9. Does the group want EmployeeDirect:Health Benefits Online available to enrollees? Yes No

This Web-based system gives enrollees the ability to view their health benefits record and make certain changes without submitting a form

10. Complete a premium table for each plan this group will offer.

- Minimum Employer Contribution:
- Full-time: 80% of average Self Only cost
- No employer contribution is required for dependents if more than 75% of eligible employees enroll
- If less than 75% enroll, the employer must pay at least 20% of the cost of dependent coverage
- If part-time coverage is offered, the employer must pay a minimum of 50% of the amount contributed toward full-time employee coverage at all membership levels
- HDHP contributions are calculated separately from other contribution calculations
- Minimum employer contributions for HDHP are 80% full-time Self Only cost and 20% of dependent cost
- Higher employer contributions are permitted

Key Advantage Expanded

Premium Rate from Proposal	Self Only		Self + One		Self + Family	
	Premium Rate: \$ _____		Premium Rate: \$ _____		Premium Rate: \$ _____	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time Employee	\$	\$	\$	\$	\$	\$
Part-time Employee	\$	\$	\$	\$	\$	\$
Early Retiree, Survivor of Retiree	\$	\$	\$	\$	\$	\$
COBRA Qualified Beneficiary	\$	\$	\$	\$	\$	\$

Key Advantage 250

Premium Rate from Proposal	Self Only		Self + One		Self + Family	
	Premium Rate: \$ _____		Premium Rate: \$ _____		Premium Rate: \$ _____	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time Employee	\$	\$	\$	\$	\$	\$
Part-time Employee	\$	\$	\$	\$	\$	\$
Early Retiree, Survivor of Retiree	\$	\$	\$	\$	\$	\$
COBRA Qualified Beneficiary	\$	\$	\$	\$	\$	\$

Key Advantage 500

Premium Rate from Proposal	Self Only		Self + One		Self + Family	
	Premium Rate: \$ _____		Premium Rate: \$ _____		Premium Rate: \$ _____	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time Employee	\$	\$	\$	\$	\$	\$
Part-time Employee	\$	\$	\$	\$	\$	\$
Early Retiree, Survivor of Retiree	\$	\$	\$	\$	\$	\$
COBRA Qualified Beneficiary	\$	\$	\$	\$	\$	\$

GROUP NAME _____

Key Advantage 1000

Premium Rate from Proposal	Self Only		Self + One		Self + Family	
	Premium Rate: \$ _____		Premium Rate: \$ _____		Premium Rate: \$ _____	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time Employee	\$	\$	\$	\$	\$	\$
Part-time Employee	\$	\$	\$	\$	\$	\$
Early Retiree, Survivor of Retiree	\$	\$	\$	\$	\$	\$
COBRA Qualified Beneficiary	\$	\$	\$	\$	\$	\$

High Deductible Plan

Premium Rate from Proposal	Self Only		Self + One		Self + Family	
	Premium Rate: \$ _____		Premium Rate: \$ _____		Premium Rate: \$ _____	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time Employee	\$	\$	\$	\$	\$	\$
Part-time Employee	\$	\$	\$	\$	\$	\$
Early Retiree, Survivor of Retiree	\$	\$	\$	\$	\$	\$
COBRA Qualified Beneficiary	\$	\$	\$	\$	\$	\$

Kaiser HMO

Premium Rate from Proposal	Self Only		Self + One		Self + Family	
	Premium Rate: \$ _____		Premium Rate: \$ _____		Premium Rate: \$ _____	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time Employee	\$	\$	\$	\$	\$	\$
Part-time Employee	\$	\$	\$	\$	\$	\$
Early Retiree, Survivor of Retiree	\$	\$	\$	\$	\$	\$
COBRA Qualified Beneficiary	\$	\$	\$	\$	\$	\$

Advantage 65

Premium Rate from Proposal	Self Only	
	Premium Rate: \$ _____	
	Employer	Enrollee
Medicare Retiree, Survivor of Retiree	\$	\$
COBRA Qualified Beneficiary	\$	\$

Advantage 65 + Dental & Vision

Premium Rate from Proposal	Self Only	
	Premium Rate: \$ _____	
	Employer	Enrollee
Medicare Retiree, Survivor of Retiree	\$	\$
COBRA Qualified Beneficiary	\$	\$

Option 1: Medicare Complimentary

Premium Rate from Proposal	Self Only	
	Premium Rate: \$ _____	
	Employer	Enrollee
Medicare Retiree, Survivor of Retiree	\$	\$
COBRA Qualified Beneficiary	\$	\$

11. Mailing Address: This address is used for communications and shipping of materials.

Street or PO Box: _____ Suite: _____
 City: _____ State: _____ Zip+4: _____ - _____

12. Shipping Address: This address is used for shipping materials. Shipping Address same as Mailing Address

Street or PO Box: _____ Suite: _____
 City: _____ State: _____ Zip+4: _____ - _____

13. Billing Address: This address is used for shipping materials. Shipping Address same as Mailing Address

Street or PO Box: _____ Suite: _____
 City: _____ State: _____ Zip+4: _____ - _____

14. Benefits Administrator: This is the person who handles inquiries about eligibility and enrollment forms. Primary HuRMan User.

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____
 Title: _____ Nickname: _____
 Phone: () _____ - _____ ext. _____ Fax: () _____ - _____ ext. _____
 Email: _____

15. Benefits Executive: This is the person who authorizes the renewal.

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____
 Title: _____ Nickname: _____
 Phone: () _____ - _____ ext. _____ Fax: () _____ - _____ ext. _____
 Email: _____

16. Billing Administrator: This is the person who receives and handles inquiries about billing.

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____
 Title: _____ Nickname: _____
 Phone: () _____ - _____ ext. _____ Fax: () _____ - _____ ext. _____
 Email: _____

17. Billing Executive: This is the person who authorizes premium payments.

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____
 Title: _____ Nickname: _____
 Phone: () _____ - _____ ext. _____ Fax: () _____ - _____ ext. _____
 Email: _____

18. Group (SubGroup) Tax Identification Number: _____

19. Employer Certification:

I certify that the information on this form is complete and accurate to the best of my knowledge.

Certified By: _____ Date Sent to DHRM: Month: _____ Day: _____ Year: _____
 (Signature)

Printed Name: _____ Phone: () _____ - _____ ext. _____

Title: _____