

The Local Choice Health Benefits Program Adoption Agreement



WHEREAS, the Department of Human Resource Management of the Commonwealth of Virginia (hereinafter referred to as the “Department”), has established the Health Benefits Program (hereinafter referred to as the “Program”) effective July 1, 1990, and

WHEREAS, the Governor has approved such Program; and

WHEREAS, pursuant to 2.2-1204 of the Code of Virginia, local employers may, by making proper application and complying with the regulations governing the Program, participate in the Program; and

WHEREAS, _____ (hereinafter called the “Employer”) is eligible to participate in the Program and become a party to any agreements established to carry out the funding of the Program, and wishes to adopt said Program for the benefit of its eligible employees, and to become a party to said agreements;

NOW, THEREFORE, by this instrument of writing, effective as of _____, 20____ (today’s date), the Employer, acting herein by and through its duly authorized representatives, hereby adopts the Program for all of its eligible employees and subscribes to the provisions of the regulations and all agreements related thereto by and between the Department and any third party, effective _____, 20____ (effective date of coverage), all in accordance with the following:

- (1) The Employer agrees to comply with the regulations governing the Program and the duties of Employers set forth therein. These duties include but are not limited to the following:
 - Complete an employer application and execute an adoption agreement;
 - Remit employer and employee contributions to the Department or its designee as set forth in regulations;
 - Provide employees with enrollment forms, process and certify the same;
 - Serve as a channel of communication between the Department and employees;
 - Otherwise assist in administration of the Program as requested by the Department.
- (2) The employer agrees to be bound by all of the terms, provisions, conditions and limitations of the Program and any agreements which are pertinent to any entity defined as an “Employer” therein, with respect to its employees eligible for participation in the Program.
- (3) The Employer agrees that the Department of Human Resource Management shall act as Plan Administrator for the Employer and its employee-participants under the Program in the same manner in which the Department acts for state employee-participants.
- (4) The Employer agrees to provide 90 days notice to the Department in the event it wishes to cease participation in the Program. The Employer shall be obligated to pay any and all contributions otherwise required through the date of termination and interest related thereto as well as any adverse experience adjustment which may apply with respect to the year the termination occurred.
- (5) The Employer understands and agrees that non-payment of contributions shall be considered a breach of the adoption agreement and the employer may be obligated to pay damages. In the event that the Employer terminates participation, such termination can only be prospective and the employer shall be obligated to pay the greater of past contributions or actual claims incurred during such period and any interest and damages that may be associated with such non-payment. In no event will the Department return to the Employer contributions made for ineligible employees.
- (6) The Employer agrees to furnish from time to time such information with reference to its employee participants as may be required by the Plan Administrator.

(continued on page 2)

- (7) The Employer agrees to reimburse the Department for expenses or settlement incurred by the Department as a result of any employee's bringing a cause of action based on the Employer's disregard of the regulations or violation of this adoption agreement.
- (8) The Effective Date of the Program shall mean, in regard to the Employer and its employee participants.

IN WITNESS WHEREOF, this agreement has been executed on behalf of the Employer, and its seal hereunto affixed by its duly authorized representatives on this day of _____, 20_____.

Attest: _____ By: _____
(Witness) (Decision Maker)

It is hereby certified that the Employer is eligible to become signatory to the Health Benefits Program and that its participation in the Program has been approved.

Department of Human Resource Management

Attest: _____ By: _____