

# 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) 371.0231



**You must order your enrollment materials using the Materials Order Form included in your renewal/ proposal notebook. Fax your order to the number shown on the Materials Order Form. Do not send order forms to TLC offices.**

Please complete all applicable information and return this sheet to the address shown above. You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan. It is important that you complete each section and sign the completed form.

**1. Group Name:** \_\_\_\_\_

**2. Effective Date:** \_\_\_\_\_ **To** \_\_\_\_\_

**3. Number of Employees Eligible/Participating**

	# Eligible Employees	# Participating Employees
Active Full Time Employees		
Active Part Time Employees		
COBRA Eligibles		
Retirees Not Eligible for Medicare		
Retirees Eligible for Medicare		

**4. List your definition of participating Full-Time Employee (including minimum hours):**

\_\_\_\_\_  
\_\_\_\_\_

**5. Do you cover Part-Time Employees?  Yes, our definition of Part-Time is:**

\_\_\_\_\_  
\_\_\_\_\_

**No, we do not cover Part-Time Employees.**

**6. Are elected members of your Governing Body eligible?**

Yes, as FT    Yes, as PT    No

**GROUP NAME** \_\_\_\_\_

**7. Have any of your definitions changed since your last renewal?**

Yes  No

If yes, please list changes: \_\_\_\_\_

**8. You must have an Open Enrollment of no longer than 30 days between April 1 and May 15 for 7/1 effective groups and between July 28 and September 10 for 10/1 effective groups. Our OE dates will be:**

\_\_\_\_\_

**9. 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 employees rather than plan participants. Employers must consider all full-time and part-time employees. Is your Group eligible for COBRA?**

Yes  No

**10. For Groups that cannot offer COBRA, we want to continue coverage for survivors of deceased employees until the end of the month following our employee's death. Full premium with continued employer and dependent contribution is required. Survivors must participate and no plan changes are permitted.**

Yes  No

**11. Please check the plan name and list rates for Benefit Plan(s) to be offered and Monthly Rate(s) for each Employee/Retiree. Enter the premium rates from your proposal/renewal rate sheet for each selected plan. Do not list the total monthly premium for your group.**

PPO Plans					HDHP	Regional Plan (if available in your area)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Key Advantage Expanded	Key Advantage 250	Key Advantage 500	Key Advantage 1000	High Deductible Health Plan	Kaiser Permanente	
<b>Active Employees – Insert Rates from Proposal/Renewal</b>						
Single						
Employee +1						
Family						
<b>Retirees <u>NOT</u> Eligible for Medicare – Insert Rates from Proposal/Renewal</b>						
Single						
Employee +1						
Family						

Retirees Eligible for Medicare	
Insert monthly Rates from Proposal/Renewal	
Advantage 65	\$
Advantage 65 with Dental/Vision	\$
Medicare Complementary	\$

**12. List Contributions**

**Minimum Employer Contribution:**

- Full-Time: 80% of average single 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% F/T single employee cost and 20% of dependent cost
- Higher contributions are permitted.

	Single		Dual		Family	
	Employer Contribution	Employee Contribution	Employer Contribution	Employee Contribution	Employer Contribution	Employee Contribution
Active Full Time	\$	\$	\$	\$	\$	\$
Active Part Time	\$	\$	\$	\$	\$	\$
Retiree Not Eligible for Medicare	\$	\$	\$	\$	\$	\$
Retiree with Medicare	\$	\$	\$	\$	\$	\$

**If you offer multiple plans, please copy and submit this page for each plan you endorse.**

**13. I hereby certify that the above information is correct to renew The Local Choice Program.**

▲ **GROUP EXECUTIVE ADMINISTRATOR (SIGNATURE REQUIRED)**

▲ **DATE**

▲ **PRINT NAME & TITLE**

▲ **TELEPHONE**

▲ **FAX**

▲ **EMAIL**



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