



THE LOCAL CHOICE HEALTH BENEFITS PROGRAM EMPLOYER RENEWAL DATA SHEET

RETURN BY 4/1/2008

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, Virginia 23219
Phone (804) 786-6460 Fax (804) 371-0231

You must order your enrollment materials using the Materials Order form included in your proposal notebook. Fax your order to the number shown at the top of the order form. Do not send your order form 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: From** _____ **To** _____

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

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

- ✓ List your definition of participating Full-Time Employee:

- ✓ If covered by the plan, list your definition of Part-Time Employee:

- ✓ Are elected members of your Governing Body eligible? Yes, as full-time Yes, as part-time No
- ✓ Have any of your definitions changed since your last renewal? Yes No
If yes, please list changes. _____
- ✓ Our 30 day Open Enrollment dates will be: _____ (between April 1 and May 15 for 7/1 effective groups & between July 28 and September 10 for 10/1 effective groups)
- ✓ 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

GROUP NAME: _____

4. Please check the plan names and list rates for Benefit Plan(s) to be offered and Monthly Premium for each Employee/Retiree. Enter the premium rates for each participant from your proposal for all selected plans, not the total monthly premium for your group.

	PPO Plans			
	<input type="checkbox"/> Key Advantage Expanded	<input type="checkbox"/> Key Advantage 200	<input type="checkbox"/> Key Advantage 300	<input type="checkbox"/> Key Advantage 500
Active Employees - Rates from Proposal				
Single	\$	\$	\$	\$
Employee +1	\$	\$	\$	\$
Family	\$	\$	\$	\$
Retirees Not Eligible for Medicare - Rates from Proposal				
Single	\$	\$	\$	\$
Employee +1	\$	\$	\$	\$
Family	\$	\$	\$	\$

	High Deductible Health Plan	HMO Plan	Retirees Eligible for Medicare		
	<input type="checkbox"/> High Deductible Health Plan	<input type="checkbox"/> Kaiser Permanente (Northern Virginia Only)	<input type="checkbox"/> Advantage 65	<input type="checkbox"/> Advantage 65 with Dental/Vision	<input type="checkbox"/> Medicare Complementary
Active Employees - Rates from Proposal			Retirees Eligible for Medicare - Rates from Proposal		
Single	\$	\$	\$	\$	\$
Employee +1	\$	\$			
Family	\$	\$			
Retirees Not Eligible for Medicare - Rates from Proposal					
Single	\$	\$			
Employee +1	\$	\$			
Family	\$	\$			

5. List Contributions

Minimum Employer Contribution for KA and HMO Plans: Full-Time: 80% of average single cost • Part-Time: 40% of average single cost • Additional cost of Dependent Coverage (if required): Full-Time: 20% of average cost • Part-Time 10% of average cost • Although permitted, no employer contribution is required for dependents if more than 75% of all eligible employees are enrolled.

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 (P/T 40% / 10%). Higher contributions are permitted.

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

6. I hereby certify that the above information is correct to renew The Local Choice Health Benefits Program.

_____/_____/_____
 Group Executive Administrator (Signature Required) / Date / Print Name & Title

Telephone: _____ Fax: _____

Email: _____