

Enrollment Form



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:

- **For Employees:** Your request to enroll must be received within 30 days of when you begin employment or become newly eligible for coverage. Your coverage begins on the first day of a month and ends on the last day of a month. 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.
- **For Retirees:** Your request to enroll must be received within 31 days of when you retire. Your coverage begins on the first day of a month and ends on the last day of a month. When your request is received by the deadline, your coverage takes effect the day after your employee coverage ends.
- **For Survivors 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. Your coverage begins on the first day of a month and ends on the last day of a month. When your request is received by the deadline, your coverage takes effect the first of the month coinciding with or following the death.
- **For Extended Coverage/COBRA Qualified Beneficiaries:** 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. The attached enrollment form is used to make changes in your existing Extended Coverage/COBRA election.

■ **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.

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.

How do I cancel coverage?

■ **For Retirees and Survivors:** You may request to remove family members prospectively or cancel coverage for yourself and all covered family members at any time by completing the attached enrollment form. The change becomes effective the first of the month after your request is received. Once coverage is cancelled, it cannot be reinstated in the future. Your Benefits Administrator can help with specific questions.

■ **For Extended Coverage/COBRA Qualified Beneficiaries:** You may request to remove family members prospectively at any time 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 before the end of the maximum period, stop paying the total premium and coverage will cease at the end of the payment grace period. Refer to your Extended Coverage/COBRA Election Notice for details.

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PART 1: IDENTIFICATION OF THE PERSON SUBMITTING THIS FORM

Employee Retiree Survivor Extended Coverage/COBRA Qualified Beneficiary
Health Plan ID or Social Security Number: _____ Female Male Date of Birth: Month: _____ Day: _____ Year: _____
First Name: _____ Middle Initial: _____ Last Name: _____ Suffix (Jr, Sr, II, III): _____
Street or PO Box: _____ City: _____ State: _____ Zip+4: _____ - _____
Work Phone: () _____ - _____ Work Email: _____
Home Phone: () _____ - _____ Home Email: _____

PART 2: REASON FOR SUBMITTING THIS FORM

- A. Initial Enrollment:
 Full-time Employee Part-time Employee Hire date or date eligible for coverage: Month: _____ Day: _____ Year: _____
 Early Retiree Medicare Retiree Last day of prior coverage: Month: _____ Day: _____ Year: _____
 Surviving Spouse Surviving Child Deceased's Date of Death: Month: _____ Day: _____ Year: _____
Deceased's Health Plan ID or Social Security No. _____
- B. Open Enrollment
- C. Qualifying Mid-Year Event (supporting documentation): Event Date: Month: _____ Day: _____ Year: _____
- Events consistent with adding family members to coverage:*
 Marriage (marriage certificate)
 Birth or Adoption (birth certificate or adoption agreement)
 Permanent custody granted or a judgment, decree, or other order to add an eligible child (court order)
 Eligible family member's Open Enrollment or a significant change under their employer's plan (employer documentation)
 Eligible family member loses eligibility for Medicare, Medicaid or other government plan (government documentation)
 Eligible family member qualifies under other HIPAA Special Enrollment (HIPAA certificate)
- Events consistent with removing family members from coverage:*
 Divorce (divorce decree)
 Death of spouse or child (documentation validating death)
 Covered child loses eligibility (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)
 Eligible family member's Open Enrollment or significant change under their employer's plan (employer documentation)
- Other Events validated by your Benefits Administrator:* Event Date: Month: _____ Day: _____ Year: _____
Employment Change: Full-time to Part-time Part-time to Full-time Unpaid Leave Began Unpaid Leave Ended
 Move affecting eligibility for a health care plan
 Remove family member prospectively
 Other: _____
- Extend the length of Extended Coverage/COBRA:* Event Date: Month: _____ Day: _____ Year: _____
 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: Month: _____ Day: _____ Year: _____
- D. Cancel coverage for myself and my eligible family members. I understand that once our coverage is cancelled, it cannot be reinstated.

PART 3: ELECTION FOR SELF ONLY HEALTH CARE COVERAGE

- A. I want to waive enrollment in health care coverage.
- B. I want to be covered under my spouse's TLC plan. Spouse's Health Plan ID or Social Security Number: _____
- C. I want coverage for myself only under the plan checked below – no family member(s) will be covered:
 Key Advantage Expanded Key Advantage 250 Key Advantage 500 Key Advantage 1000
 High Deductible Health Plan Kaiser HMO
Medicare-coordinating Plans: Advantage 65 Advantage 65 + Dental & Vision Option I: Medicare Complimentary

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PART 4: ELECTION FOR SELF AND FAMILY MEMBER(S) HEALTH CARE COVERAGE

I want coverage for myself and my family member(s). Only the persons identified below will be covered - not listing a person removes them.
 Codes: M=Myself; H=Husband; W=Wife; D=Daughter; S=Son; SD=Stepdaughter; SS=Stepson; OF=Other Female Child; OM=Other Male Child

A. Person(s) to be covered under the plan checked below:

- Key Advantage Expanded
 Key Advantage 250
 Key Advantage 500
 Key Advantage 1000
 High Deductible Health Plan
 Kaiser HMO

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Date of Birth (MM/DD/YYYY)	Social Security Number (NNN-NN-NNNN)
_____	_____	_____	_____	____/____/____	____-____-____
_____	_____	_____	_____	____/____/____	____-____-____
_____	_____	_____	_____	____/____/____	____-____-____
_____	_____	_____	_____	____/____/____	____-____-____
_____	_____	_____	_____	____/____/____	____-____-____
_____	_____	_____	_____	____/____/____	____-____-____

B. Person to be covered under the Medicare-coordinating plan checked below:

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

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Date of Birth (MM/DD/YYYY)	Social Security Number (NNN-NN-NNNN)
_____	_____	_____	_____	____/____/____	____-____-____

Refer to Medicare card: ID: _____ Part A Date: _____ Part B Date: _____

C. Person to be covered under the Medicare-coordinating plan checked below:

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

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Date of Birth (MM/DD/YYYY)	Social Security Number (NNN-NN-NNNN)
_____	_____	_____	_____	____/____/____	____-____-____

Refer to Medicare card: ID: _____ Part A Date: _____ Part B Date: _____

PART 5: CERTIFICATION AND AUTHORIZATION OF THE PERSON SUBMITTING THIS FORM:

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. Keep a copy for your records before you submit it to your Benefits Administrator. Once the election goes into effect, it may not be changed without a subsequent qualifying mid-year event or until the next Open Enrollment.

- Employee
 Retiree
 Survivor
 Extended Coverage/COBRA Qualified Beneficiary

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 information on this enrollment form and that it is complete and accurate to the best of my knowledge. 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: _____ Month: _____ Day: _____ Year: _____

PART 6: CERTIFICATION AND AUTHORIZATION OF THE BENEFITS ADMINISTRATOR:

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

Date Form Received: Month: _____ Day: _____ Year: _____ Date Sent to DHRM: Month: _____ Day: _____ Year: _____

Group Bill Direct Bill Monthly Premium: \$ _____ Effective Date: Month: _____ Day: _____ Year: _____

Authorized by: Name: _____ Group No. _____ - _____ - _____ Phone: (_____) _____ - _____

Send authorized form by: Email: OHB@dhrm.virginia.gov, Fax: (804) 371-0231, or Mail: DHRM - TLC, 101 N 14th St Fl 13, Richmond, VA 23219