Commonwealth of Virginia Health Benefits Program Application

The Local Choice

This application must be used by local employers to apply for coverage under The Local Choice Health Benefits Program sponsored by the Commonwealth of Virginia. A **signed original application** is required in order for The Local Choice to release rate information.

YOUR CURRENT HEALTH CARE COVERAGE SHOULD NOT BE TERMINATED UNTIL THIS APPLICATION AND AN ADOPTION AGREEMENT HAVE BEEN APPROVED AND ACCEPTED IN WRITING BY THE COMMONWEALTH OF VIRGINIA.

Today's Date: ____________________

I. GENERAL INFORMATION

1. Full name of local employer ____________________

   Type of group *(check both if applicable)*

   ☐ Local government ☐ School district ☐ Other (Please indicate): ____________________

2. Street Address ____________________

   Mailing Address/P.O. Box ____________________

   City ____________________ Zip Code ____________________

3. Plan administration Executive Correspondent *(This person will receive renewal and contractual information.)*

   Name ____________________ Telephone Number ____________________

   Title ____________________ Fax Number ____________________

   E-mail Address ____________________

   Address *(if different from item 2. above)* ____________________

4. Group Benefits Administrator *(This person will receive routine plan administration materials.)*

   Name ____________________ Telephone Number ____________________

   Title ____________________ Fax Number ____________________

   E-mail Address ____________________

   Address *(if different from item 2. above)* ____________________

5. Has your group previously participated in The Local Choice Health Benefits Program? ☐ No ☐ Yes – From __________ to __________.

   month/year *month/year*

6. **Applicable only for employers who offer no health care coverage to their employees** and whose employees elect to individually join the Health Benefits Program.

   It is hereby certified that ____________________ (the Employer) offers no health care plan to employees. The Employer will, on behalf of employees who elect to individually join the Program, collect and remit premiums and assist the Department of Human Resource Management as necessary.

   By: ____________________

   (Name) *(Title)* *(Local Employer)*

   (These Employers do not need to complete Section III.)

II. ELIGIBILITY REQUIREMENTS

1. Define permanent **full-time** employees to be **eligible** for coverage. ____________________

2. Are any permanent **full-time** employees to be **excluded** from eligibility? ☐ Yes ☐ No

   If yes, please define: ____________________

3. Are permanent **part-time** employees (20 hours or more per week) to be **eligible**? ☐ Yes ☐ No
   If yes, please define: ______________________________

4. Are any permanent **part-time** employees to be **excluded** from eligibility? ☐ Yes ☐ No
   If yes, please define: ______________________________

5. Are dependents to be offered coverage? ☐ Yes ☐ No
   If yes, eligibility requirements will be outlined in benefits material.

6. Are retirees to be offered coverage? ☐ Yes ☐ No
   If yes, please explain terms and conditions including definition of retiree eligibility. ______________________________

7. Are other employees to be eligible? ☐ Yes ☐ No
   If yes, please explain terms and conditions including definition of retiree eligibility. ______________________________

8. Please describe any other employees to be specifically excluded from coverage. ______________________________

9. Please specify whether the eligibility information in this section differs in any way from the eligibility criteria for your current health benefits program. ______________________________

10. Will employees be required to contribute to obtain employee coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and employee contributions:

11. Will employees be required to contribute to obtain dependent coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and employee contributions:

12. Do you offer employees a pre-tax premium program? ☐ Yes ☐ No

13. Will retirees be required to contribute to obtain retiree coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and retiree contributions:

14. Will retirees be required to contribute to obtain dependent coverage? ☐ Yes ☐ No
    If yes, please explain your current and future policy with regard to the amounts of employer and retiree contributions:

15. Proposed effective date of participation: Month ____________ Day ____________ Year ____________

III. FINANCIAL AND STATISTICAL INFORMATION

• **Please Complete For All Current Health Benefits Plan(s) Offered By Your Group:**

1. Provide current carrier(s), policy number(s), name and type of plan (HMO, PPO, POS, indemnity, etc):

   Name ______________________ Policy # ______________________ Type Plan ____________

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   Name ______________________ Policy # ______________________ Type Plan ____________

2. Provide a benefit plan booklet or certificate outlining the current health benefits plan(s), and note any recent changes for each of the plans maintained by your group.

3. Please attach current rates, renewal rates (if available) and "experience" analysis by the incumbent carrier(s) for the past three years.
   ☐ Information Attached

   ____

4. Please attach, if applicable, a full explanation of any special financial arrangements such as fully insured, Administrative Services Only (ASO), holding reserve funds, aggregate stop loss, deficit recovery agreements, minimum premium, etc. that are in effect.
   ☐ Information Attached

   ____

IV. PLAN DEMOGRAPHICS

1. Provide current census information about eligible employees/retirees for each benefit plan offered to include the details listed below. You may use the chart provided in item 4, attach the information in a separate report, or send it electronically to **tlc@dhrm.virginia.gov**. **All groups, please complete items 2 and 3.**

   • Coverage category (active, retiree, COBRA, all other employees)
   • Employee identification number
   • Gender and date of birth
   • Type of membership (Employee Only, Employee and One Dependent, Family or waived status)
   • Job classification (regular full-time or regular part-time)

2. Please check the type of health benefits plan(s) maintained by your group.

   ☐ HMO ☐ PPO ☐ POS ☐ Indemnity

3. **NUMBER OF TOTAL ELIGIBLES** ____________

   Number of Active Employee Participants ____________ Number of Retiree Participants NOT Eligible for Medicare ____________

   Number of COBRA Participants ____________ Number of Retiree Participants Eligible for Medicare ____________

Do you currently have group coverage with Anthem Blue Cross and Blue Shield? ☐ Yes ☐ No
If yes, you do not need to submit financial or statistical information. However, we must have your signature to authorize release of this information from Anthem so that we can establish rates for the benefit plans requested.

Signature______________________ **Title**______________________

4. Complete the charts to show the demographic make-up of your group, or attach the data in a separate report.

ACTIVE COVERAGE

	Number Of Employee Only		Number Of Employee Plus One Dependent		Number Of Family	
Age Range	Male	Female	Male	Female	Male	Female
0-29						
30-39						
40-44						
45-49						
50-54						
55-59						
60-64						
Over 65						
Total						

RETIREE COVERAGE

	Number Of Retiree Only		Number Of Retiree Plus One Dependent		Number Of Retiree Plus Family	
Age Range	Male	Female	Male	Female	Male	Female
0-55						
56-59						
60-64						
65-69						
70-74						
75-79						
Over 80						
Total						

V. CERTIFICATION

I certify that the information supplied by me on this application is accurate to the best of my knowledge.

Signature ______________________________ **Title** ______________________________

Application prepared by *(please print)* ______________________________

(Name) *(Title)* *(Date)*

Telephone number (________) ____________________ Fax number (________) ____________________

E-mail Address______________________________

Forward this completed application to:

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
(804) 786-6460
E-mail: tlc@dhrm.virginia.gov
Web: www.thelocalchoice.virginia.gov *(This form is available on the Web site.)*