

# Employer Data Sheet

**RETURN BY APRIL 1, 2011**

**Return this Data Sheet to:**  
The Local Choice Health Benefits Program  
Commonwealth of Virginia  
Department of Human Resource Management  
101 North 14<sup>th</sup> Street – 13<sup>th</sup> 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 proposal notebook. Fax your order to the number shown on the Materials 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:** \_\_\_\_\_ **To** \_\_\_\_\_

3. **Number of Persons 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:**  
\_\_\_\_\_

5. **Do you cover Part-Time Employees? If yes, provide your definition of Part-Time:**  
\_\_\_\_\_

6. **Are elected members of your Governing Body eligible?**  Yes, as FT  Yes, as PT  No

7. **Have any of your definitions changed since your last renewal?**  Yes  No  
If yes, please list changes: \_\_\_\_\_

8. **Our 30 day Open Enrollment dates will be:** \_\_\_\_\_ **(between April 1 and May 15 for 7/1 effective groups and between July 28 and September 10 for 10/1 effective groups)**

9. **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 not plan changes are permitted.**  Yes  No

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

**10. Please check the plan name 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 250	<input type="checkbox"/> Key Advantage 500	<input type="checkbox"/> Key Advantage 1000
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	Regional Plan (if available in your area)
	<input type="checkbox"/> High Deductible Health Plan	<input type="checkbox"/> Kaiser Permanente
Active Employees- Rates from Proposal		
Single	\$	\$
Employee +1	\$	\$
Family	\$	\$
Retirees Not Eligible for Medicare -Rates from Proposal		
Single	\$	\$
Employee +1	\$	\$
Family	\$	\$

Retirees Eligible for Medicare	
Retirees Eligible for Medicare – Rates from Proposal	
<input type="checkbox"/> Advantage 65	\$
<input type="checkbox"/> Advantage 65 with Dental/Vision	\$
<input type="checkbox"/> Medicare Complementary	\$

**11. List Contributions – Minimum Employer Contribution for KA and Regional 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	\$	\$	\$	\$	\$	\$

**12. 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: \_\_\_\_\_