2017-18 Employer Data Worksheet

The Local Choice Program
Phone (804) 786-6460

On-line Employer Data Sheet is DUE: April 1, 2017

This is a Worksheet only.

A late Employer Data Sheet will delay group set-up. Contact the TLC Program Manager with any questions about this form.

1. Enter the group name and check 'yes' or 'no for each type of group. If 'yes' is checked, enter the DHRM Group Number. A Combined Government & School Group must submit two Employer Data Sheets – each Data Sheet should identify both group numbers.

Enter Group Name:					
Stand-alone Government Group:	☐Yes ☐No	Enter DHRM Group Number:	Agy:	047	Grp:
Stand-alone School Group:	☐Yes ☐No	Enter DHRM Group Number:	Agy:	048	Grp:
Combined Government & School Group:	☐Yes ☐No	Enter DHRM Group Number for Government:	Agy:	047	Grp:
		Enter DHRM Group Number for School:	Agy:	048	Grp:

2. Check 'yes' or 'no' for existing group or new group and type of renewal. For a new group, enter the begin date and end date.

Existing Group–July Renewal	☐Yes ☐No	Begins: 07/01/2017 Ends: 06/30/2018
Existing Group–October Renewal	☐Yes ☐No	Begins: 10/01/2017 Ends: 09/30/2018
New Group–July Renewal	☐Yes ☐No	Enter Dates: Begins: _____ / _____ / 2017 and Ends: ☐06/30/2018 or ☐06/30/2019
New Group–October Renewal	☐Yes ☐No	Enter Dates: Begins: _____ / _____ / 2017 and Ends: ☐09/30/2018 or ☐09/30/2019

3. Check 'yes' or 'no' for the number of subdivisions. If 'yes' enter the information for each subdivision.

   A group must have a subdivision for each Federal Employer Identification Number (FEIN). Subdivisions with the same FEIN are also permitted. Subdivisions with the same FEIN may have separate group contacts, but must be set-up with the same rules, plan choices, and cost-sharing. Subdivisions with a different FEIN may have separate contacts, separate rules, and separate cost-sharing, but must offer the same plan choices. A group offering 10-month rates must have a separate subdivision.

Only One Subdivision : ☐Yes ☐No		Enter Subdivision FEIN:			
More than One Subdivision: ☐Yes ☐No		Enter information below for each subdivision:			
Subdivision Name:	DHRM Code:	Subdivision FEIN:	Same Rules? (Page 2)	Same Cost-Sharing? (Page 3)	Same Contacts? (Page 4)
	Sub:		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Sub:		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Sub:		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Sub:		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Sub:		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

If a subdivision has different rules, cost-sharing, or contacts, attach the appropriate page(s) showing the differences to this Data Sheet.

Subdivision Name: _____DHRM Group Number: Agy:_____Grp:_____Sub_____

4. Check 'yes' or 'no' for each enrollee category to be offered coverage. If 'yes' is checked, enter the current counts and calculate the total participation percentage. Enter '0' if no one is included in a category.

Enrollee Category	Offer Coverage?	Billing Method	Enter Enrolled Count	Enter Waived Count	Enter Eligible Count (Enrolled + Waived)
Full-time Employees: TLC requires 20 minimum hours per week	☐Yes ☐No	Bill the Group			
Elected Officials with full-time premium:	☐Yes ☐No	Bill the Group			
Part-time Employees: TLC requires 20 minimum hours per week	☐Yes ☐No	Bill the Group			
Elected Officials with part-time premium:	☐Yes ☐No	Bill the Group			
Enter Total Participation: (Sum each column.)					
Enter Total Participation Percentage: (Divide the Enrolled Count Total by the Eligible Count Total and round down)					%

5. Check 'yes' or 'no' for each enrollee category to be offered coverage. If 'yes' is checked, enter the current counts and select a billing method if an option is given. Enter '0' if no one is included in a category.

Enrollee Category	Offer Coverage?	Enter Enrolled Count	Select Billing Method
Survivors of Employees and Elected Officials: If selected, survivors continue in the same coverage and with the same employer premium contribution for one extra month. This option is intended for a group unable to offer Extended Coverage/COBRA coverage.	☐Yes ☐No		Bill the Group
Extended Coverage/COBRA Qualified Beneficiaries: Applies to an employer that has at least 20 employees on more than 50 percent of its typical business days in the previous calendar year.	☐Yes ☐No		☐Bill the Group ☐Third-Party Administrator* ☐Direct Bill the Member
Early Retirees - not eligible for Medicare: Must be at least age 55 with 5 years of service with your group or age 50 with 10 years of service with your group. Groups that offer coverage to Medicare Retirees must offer coverage to Early Retirees; there can be no gap in coverage.	☐Yes ☐No		☐Bill the Group ☐Third-Party Administrator* ☐Direct Bill the Member
Medicare Retirees – eligible for Medicare: Enrollee participation in Parts A, B and D of Medicare is required to receive maximum benefits. If you choose not to cover your Medicare retirees, coverage ends for the retiree and all covered dependents with the retiree's Medicare eligibility.	☐Yes ☐No		☐Bill the Group ☐Third-Party Administrator* ☐Direct Bill the Member
Survivors of Retirees:	☐Yes ☐No		Billed as Early Retiree or Medicare Retiree based on plan selected

* When a Third-Party Administrator (TPA) is used, Direct Bill is not permitted.

6. Does this group have a plan document with different rules for enrollment or election changes than the TLC rules? ☐Yes ☐No

   The TLC Enrollment form describes in general terms when enrollment or election changes may be made under TLC rules. It is the responsibility of the employer group with different rules for enrollment or election changes than TLC to enforce those rules.

7. Enter Open Enrollment Period dates. Begins: Month:_____ Day: _____ Ends: Month: _____ Day: _____

   TLC requires an Open Enrollment period no longer than 30 days between April 1 and May 15 for groups effective July 1 and between July 28 and September 10 for groups effective October 1. New groups, effective mid-plan year, must have the Open Enrollment Period approved by the TLC Program Manager prior to the effective date.

Subdivision Name: _____DHRM Group Number: Agy:_____Grp:_____Sub_____

8. Check 'yes or 'no' for each plan choice. If 'yes' is selected, check a plan and enter the premium totals from the renewal sheet and the employer and enrollee contribution amounts for each tier.

   - Groups with 14 or fewer eligible employees may offer only one plan. Groups with 15 to 99 eligible employees may offer two plans. Groups with more than 99 eligible employees may offer two Key Advantage plans and a High Deductible Plan and/or Kaiser if available. Groups offering a Key Advantage Plan choice or a High Deductible Plan choice must offer both the Preventive Option and the Comprehensive Option. Groups offering coverage to Medicare Retirees may choose one Medicare plan.
   - Employer contributions for each plan offered must meet or exceed the minimum employer funding requirements which are based on the total participation percentage from #4 and the plan(s) offered. When two or more plans are offered, premium averaging may be used. Premium averaging is based on the un-weighted average of the plans offered excluding the High Deductible Plan which is calculated separately. A Medicare plan offering is not subject to minimum employer requirements. Minimum Employer Contribution Requirements:
     - All Key Advantage Plans, the High Deductible Plan with employer HSA/HRA funding, or the Kaiser HMO:
       Full-time: 80% of the Self Only Comprehensive Premium plus 20% of the Comprehensive dependent cost. The dependent contribution requirement is waived when the participation percentage (from #4) is 75% or more.
       Part-time: 50% of the full-time employer amount for each tier.
     - High Deductible Plan without employer HSA/HRA funding:
       Full-time: 80% of the Self Only Comprehensive Premium plus 20% of the Comprehensive dependent cost regardless of participation percentage (from #4)
       Part-time: 50% of the full-time employer amount for each tier.

Key Advantage Plan Choice 1: ☐Yes ☐No	☐KA Expanded ☐KA 250 ☐KA 500 ☐KA 1000					
	Self Only		Self + One		Self + Family	
Preventive Premiums	$		$		$	
Comprehensive Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Comprehensive Contributions - Full-time	$	$	$	$	$	$
Comprehensive Contributions - Part-time	$	$	$	$	$	$

Key Advantage Plan Choice 2: ☐Yes ☐No	☐KA Expanded ☐KA 250 ☐KA 500 ☐KA 1000					
	Self Only		Self + One		Self + Family	
Preventive Premiums	$		$		$	
Comprehensive Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Comprehensive Contributions - Full-time	$	$	$	$	$	$
Comprehensive Contributions - Part-time	$	$	$	$	$	$

High Deductible Plan Choice: ☐Yes ☐No	☐HDP with employer HSA/HRA funding ☐HDP without employer HSA/HRA funding					
	Self Only		Self + One		Self + Family	
Preventive Premiums	$		$		$	
Comprehensive Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Comprehensive Contributions - Full-time	$	$	$	$	$	$
Comprehensive Contributions - Part-time	$	$	$	$	$	$

Regional HMO Choice: ☐Yes ☐No	☐Kaiser HMO					
	Self Only		Self + One		Self + Family	
Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Contributions Full-time	$	$	$	$	$	$
Contributions Part-time	$	$	$	$	$	$

Medicare Plan Choice: ☐Yes ☐No	☐Advantage 65 ☐Advantage 65 + Dental/Vision ☐Option 1
	Self Only Total Premium: $

Subdivision Name: _____DHRM Group Number: Agy:_____Grp:_____Sub_____

9. Enter Mailing Address.

Street or P O Box:		Suite:
City:	State:	Zip+4:

10. Enter Shipping Address (physical location). ☐Shipping Address same as Mailing Address

Street or P O Box:		Suite:
City:	State:	Zip+4:

11. Enter Benefits Administrator's information. This is the person who handles eligibility and enrollment.

First Name:	Middle Initial:	Last Name:	Suffix:
Title:			Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -	
Email:			ID or SSN:

12. Enter Benefits Executive's information. This is the person who authorizes the renewal.

First Name:	Middle Initial:	Last Name:	Suffix:
Title:			Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -	
Email:			ID or SSN:

13. Enter Billing Administrator's information. This is the person who receives and handles inquiries about billing.

First Name:	Middle Initial:	Last Name:	Suffix:
Title:			Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -	
Email:			ID or SSN:

14. Enter Billing Executive's information. This is the person who authorizes premium payments.

First Name:	Middle Initial:	Last Name:	Suffix:
Title:			Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -	
Email:			ID or SSN:

15. Employer Certification. I certify that the information on this form is complete and accurate to the best of my knowledge. ☐Yes ☐No

Signature:		Date Signed (MM/DD/YYYY):
Printed Name:	Phone: ( ) -	Ext:
Title:		Date sent to DHRM (MM/DD/YYYY):