

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:

- **As Employee:** Your request to enroll must be received within 30 days of when you begin employment or become newly eligible for coverage. 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.
- **As Retiree:** Your request to enroll must be received within 31 days of when you retire. When your request is received by the deadline, your coverage takes effect the day after your employee coverage ends.
- **As Survivor 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. When your request is received by the deadline, your coverage takes effect the first of the month coinciding with or following the death.
- **As Extended Coverage/COBRA Qualified Beneficiary:** Your initial request to enroll must be submitted on the Election Form provided in your Election Notice or by completing this Enrollment form. 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.

■ **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.

For Retirees, Survivors, and Extended Coverage/COBRA Qualified Beneficiaries: You may request to remove family members prospectively 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, send your request in writing to TLC or your Benefits Administrator before you stop paying the total premium. Coverage will cease at the end of the payment grace period.

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.

A10246

The Local Choice Health Benefits Program Enrollment Form

PART 3: IDENTIFICATION OF THE PERSON SUBMITTING THIS ELECTION REQUEST

Health Plan ID or Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____ / _____ / _____
 First Name: _____ Middle Initial: _____ Last Name, Suffix (Jr, Sr, II, III): _____
 Street or PO Box: _____
 City: _____ State: _____ Zip+4: _____ - _____ Female Male
 Work Phone (999) 999-9999: (_____) - _____ - _____ Personal Phone (999) 999-9999: (_____) - _____ - _____
 Email: _____
Full-time Employee Part-time Employee Retiree Survivor of Retiree Extended Coverage/COBRA Qualified Beneficiary

PART 4: HEALTH CARE COVERAGE ELECTION REQUEST

- A. I want to waive enrollment in this health care coverage at this time. Indicate below if you have other health care coverage.
 I am enrolled in other health care coverage. Other coverage ID Number: _____
 Plan Administrator: _____ Policy Holder's Name: _____
 I am not covered by any other health care coverage.
- B. Indicate your plan selection and the person(s) to be covered by this selection. Do not list a person you want removed from coverage.
KA Expanded-Comprehensive KA 500-Comprehensive High Deductible Plan-Comprehensive
KA Expanded-Preventive KA 500-Preventive High Deductible Plan-Preventive
KA 250-Comprehensive KA 1000-Comprehensive Kaiser HMO
KA 250-Preventive KA 1000-Preventive

IMPORTANT: List each person, including yourself, that you want covered by this plan - include a code for each person.
 Codes: M=Myself; SM=Male Spouse; SF=Female Spouse; D=Daughter; S=Son; SD=Stepdaughter; SS=Stepson; O=Other Approved Child

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Sex (F/M)	Date of Birth (MM/DD/YY)	Social Security Number (999-99-9999)
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -

- C. Indicate your Medicare-coordinating plan selection and the person(s) to be covered by this selection – include a code for each person.
Advantage 65 Advantage 65 + Dental & Vision Option I: Medicare Complimentary

Code	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Sex (F/M)	Date of Birth (MM/DD/YY)	Social Security Number (999-99-9999)
					/ /	- -
Medicare ID:		Part A (MM/DD/YY): / /			Part B (MM/DD/YY): / /	
					/ /	- -
Medicare ID:		Part A (MM/DD/YY): / /			Part B (MM/DD/YY): / /	

PART 5: CERTIFICATION AND AUTHORIZATION OF THE BENEFITS ADMINISTRATOR FOR THIS ELECTION

Form Received (MM/DD/YY): _____ / _____ / _____ Effective Date (MM/DD/YY): _____ / _____ / _____ Group Bill Direct Bill
 Extended Coverage/COBRA ends (MM/DD/YY): _____ / _____ / _____ DHRM Group No: _____ - _____ - _____
 I certify that the information on this form and in the required supporting documentation is complete and accurate to the best of my knowledge.
 Authorized by: Name: _____ Phone (999) 999-9999: (_____) - _____ - _____ Ext: _____
 Send authorized form by: Email: TLC@dhrm.virginia.gov, Fax: (804) 786-1708, or Mail: DHRM-TLC, 101 N 14th St Fl 13, Richmond, VA 23219