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 (life event), whichever comes first. Once you have submitted a valid election during the enrollment window and that election takes effect, it is binding and may not be changed.
  - **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.
- **Open Enrollment:** Open Enrollment occurs each year. It is your annual opportunity to request enrollment or make election changes. When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the supported documentation, do not miss enrollment deadline. The documentation can be submitted at a later date. Contact your Benefits Administrator with specific questions.
- **Qualifying Mid-Year Event (Life 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 life 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 will be retroactive to the date of birth, adoption or placement for adoption. If you miss the 60-day deadline, you must wait for Open Enrollment or another qualifying mid-year event (life event), whichever comes first. Other events may permit limited enrollment or election changes. The countdown begins on the day of the event. Once you have submitted a valid election during this enrollment window and that election takes effect, it is binding and may not be changed. See your Benefits Administrator with specific questions.

  For Retirees and Survivors: 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.

The Local Choice Health Benefits Program Enrollment Form

PART 1: CERTIFICATION AND AUTHORIZATION OF THE PERSON SUBMITTING THIS ELECTION REQUEST

Review, complete, and submit this enrollment form with supporting documentation to your Benefits Administrator within the required timeframe. If you have questions or need more time, contact your Benefits Administrator before the deadline. Please print or type clearly. 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.

ID (or Social Security Number): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Suffiix (Jr, Sr, II, III): _____

☐ I certify that I have reviewed the instructions on this enrollment form and that the information submitted is complete and accurate to the best of my knowledge. I understand that once this election goes into effect, it may not be changed without a subsequent qualifying mid-year event (life event) or until the next Open Enrollment. 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: _____ Date (MM/DD/YY): _____/_____/_____

☐ Full-time Employee ☐ Part-time Employee ☐ Retiree ☐ Survivor of Retiree

PART 2: REASON FOR SUBMITTING THIS ELECTION REQUEST AND REQUIRED SUPPORTING DOCUMENTATION

A. ☐ Initial Enrollment as Employee Hire Date (MM/DD/YY): _____/_____/_____

B. ☐ Initial Enrollment as Early Retiree Last Day of prior coverage (MM/DD/YY): _____/_____/_____

C. ☐ Initial Enrollment as Medicare Retiree Last Day of prior coverage (MM/DD/YY): _____/_____/_____

D. ☐ Initial Enrollment as Survivor of Retiree ☐ Spouse ☐ Child Deceased's Date of Death (MM/DD/YY): _____/_____/_____

Deceased's Name:_____ Deceased's Health Plan ID:_____

E. ☐ Open Enrollment

F. ☐ Qualifying Mid-Year Event (Life Event) [indicate the event below] Qualifying Mid-Year Event Date (Life Event): ____/_____/_____

Events consistent with adding family members to coverage: (MM/DD/YY)

- ☐ Marriage (marriage certificate)
- ☐ Birth or Adoption (birth certificate /hospital announcement or adoption agreement)
- ☐ Judgment, decree, or other order (including permanent custody) to add an eligible child (court order)
- ☐ Eligible family member lost eligibility under governmental plan (government documentation)
- ☐ Eligible family member lost eligibility for Medicare or Medicaid (government documentation)
- ☐ Eligible family member lost eligibility under their employers plan (employer documentation)
- ☐ HIPAA special enrollment due to loss of other group coverage (HIPAA certificate)

Events consistent with removing family members from coverage:

- ☐ Divorce (divorce decree)
- ☐ Death of spouse (documentation validating death)
- ☐ Death of covered child (documentation validating death)
- ☐ Covered child lost eligibility under this health plan (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)

Other Events validated by your Benefits Administrator:

Employment Change: ☐ Full-time to Part-time ☐ Part-time to Full-time ☐ Unpaid Leave Began ☐ Unpaid Leave Ended

- ☐ Significant change or Open Enrollment under the other employer's plan (employer documentation)
- ☐ Move affecting eligibility for this health plan
- ☐ Eligible participant (subscriber) waived own coverage to be added as family member under this plan
- ☐ Enrollment in a Marketplace Exchange health plan (documentation of coverage with the effective date)

☐ ***Add to existing Family Membership (documentation to support eligibility)***

PART 3: IDENTIFICATION OF THE PERSON SUBMITTING THIS ELECTION REQUEST

ID (or Social Security Number):_____ Date of Birth (MM/DD/YY): _____/_____/_____

Name:_____ Middle Initial:____ Last Name:_____ Suffiix (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

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 Expanded-Preventive
☐ KA 250-Comprehensive
☐ KA 250-Preventive
☐ KA 500-Comprehensive
☐ KA 500-Preventive
☐ KA 1000-Comprehensive
☐ KA 1000-Preventive
☐ High Deductible Plan-Comprehensive
☐ High Deductible Plan-Preventive
☐ Kaiser HMO
☐ Sentara Health HMO

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; OF=Other Female Child; OM=Other Male Child

Code	*First Name*	*Middle Initial*	*Last Name, Suffix (Jr, Sr, II, III)*	*Sex (M/F)*	*Date of Birth (MM/DD/YYYY)*	*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 l: Medicare Complimentary

Code	*First Name*	*Middle Initial*	*Last Name, Suffix (Jr, Sr, II, III)*	*Sex (M/F)*	*Date of Birth (MM/DD/YYYY)*	*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

DHRM Group No:_____

☐ I certify that this form is legible and that the information on it and in the required supporting documentation is complete and accurate to the best of my knowledge. I understand that illegible or incomplete forms will delay processing.

Authorized by: Name:_____ Phone: (_____)_____-_____ 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

2023-24 Language Assistance Statement

State Health Benefits Program

Virginia Department of HUMAN RESOURCE MANAGEMENT

The Commonwealth of Virginia's State and Local Health Benefits Programs (the "Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Nondiscrimination Notice lists the services available and how to file a complaint if you feel that the Health Plan has failed to provide these services or discriminated in another way.

ATTENTION: If you need help in the language you speak, language assistance services are available to you free of charge. Send your request for language assistance to appeals@dhrm.virginia.gov or fax to 804-786-0356.

Spanish:
ATENCIÓN: Si necesita ayuda en el idioma que habla, servicios de asistencia lingüística están a su disposición de forma gratuita. Envíe su solicitud de asistencia lenguaje para appeals@dhrm.virginia.gov~~V o por fax al 804-786-0356.

Korean:
주의 : 당신이 말하는 언어로 도움이 필요한 경우, 언어 지원 서비스를 무료로 당신에게 사용할 수 있습니다. 804-786-0356에 언어 appeals@dhrm.virginia.gov~~V하는 지원이나 팩스에 대한 요청을 보냅니다.

Vietnamese:
Chú ý: Nếu bạn cần giúp đỡ trong ngôn ngữ bạn nói, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gửi yêu cầu để được hỗ trợ ngôn ngữ đẻ appeals@dhrm.virginia.gov~~V hoặc fax 804-786-0356.

Chinese:
注意：如果你需要在你講的語言幫助，語言協助服務提供給您免費。發送您的語言協助 appeals@dhrm.virginia.gov~~V或傳真至804-786-0356請求。

Arabic:
تنبيه: إذا كنت بحاجة إلى مساعدة باللغة التي تتحدثها، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا.
أرسل طلبك للحصول على المساعدة اللغوية عبر البريد الإلكتروني إلى appeals@dhrm.virginia.gov أو عبر الفاكس إلى 804-786-0356.

Persian:
توجه: اگر شما نیاز به کمک در زبان شما صحبت می کنند، خدمات کمک زبان در دسترس شما هستند رایگان می باشد. ارسال درخواست خود را برای کمک به زبان appeals@dhrm.virginia.gov~~V.0356-786-804 یا فکس به

Amharic:
አዳምጥ: አንተ የሚናገሩት ቋንቋ እርዳታ የሚፈልጉ ከሆነ ,የ ቋንቋ እርዳታ አገ ልግሎቶች ከክፍያ ነፃ ለእርስዎ የሚ ኙ ና ቸው. 804-786-0356 ቋንቋ appeals@dhrm.virginia.gov~~V እርዳታ ወይም በ ፋክስ ጥያ ቄዎን ይላ ኩ.

Urdu:
توجہ فرمائیں: اگر آپ کو اپنی بولی جانے والی زبان میں مدد درکار ہے تو زبان میں مدد کی خدمات آپ کے لیے بالکل مفت دستیاب ہیں۔
زبان میں مدد کے لیے اپنی درخواستیں appeals@dhrm.virginia.gov پر بھیجیں یا 804-786-0356 پر فیکس کریں۔

French:
ATTENTION: Si vous avez besoin d'aide dans la langue que vous parlez, les services d'assistance linguistique sont à votre disposition gratuitement. Envoyez votre demande d'assistance linguistique pour appeals@dhrm.virginia.gov~~V ou par télécopieur au 804-786-0356.

Russian:
ВНИМАНИЕ: Если вам нужна помощь на языке вы говорите, переводческие услуги доступны бесплатно. Отправьте запрос о помощи языка к appeals@dhrm.virginia.gov~~HEAD=pobj~~V или по факсу 804-786-0356.

Hindi:
ध्यान दें: यदि आपको उस भाषा के लिए मदद की ज़रूरत है, जिस भाषा में आप बात करते हैं, तो आपके लिए भाषा सहायता सेवाएं निशुल्क में उपलब्ध हैं। भाषा की सहायता के लिए अपना अनुरोध appeals@dhrm.virginia.gov पर या फ़ैकस के लएि 804-786-0356 पर भेजें।

German:
ACHTUNG: Wenn Sie in der Sprache sprechen Sie Hilfe benötigen, die Sprache Hilfeleistungen zur Verfügung stehen Ihnen kostenlos zur Verfügung. Senden Sie Ihre Anfrage für sprachliche Unterstützung zu appeals@dhrm.virginia.gov~~V oder Fax an 804-786-0356.

Bengali:
দৃষ্টি আকর্ষণ: আপনি ভাষা আপনি কথা বলতে সাহায্য প্রয়োজন হয়, তাহলে ভাষা সহায়তা সেবা নিখরচা আপনার জন্য উপলব্ধ. appeals@dhrm.virginia.gov~~V অথবা ফ্যাক্স ভাষা সহায়তা 804-786-0356 করার জন্য আপনার অনুরোধ পাঠান.

Bassa:
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀bɛ́ìn m̀ ké gbo kpáa. Đá 804-786-0356.

Igo (Igbo):
Ntị: Ọ bụrụ na ị chọrọ enyemaka na asụsụ ị na-asụ, asụsụ aka ọrụ dị ka ị n'efu. Send gị arịrịọ maka asụsụ aka appeals@dhrm.virginia.gov~~V ma ọ bụ faksị ka 804-786-0356.

Yoruba:
Akiyesi: Ti o ba nilo iranlọwọ ninu ede ti o sọrọ, ede iranlowo iṣẹ ni o wa wa si o free ti idiyele. Fi ìbéèrè rẹ fun ede iranlowo to appeals@dhrm.virginia.gov tabi Faksi to 804-786-0356.

Filipino (Tagalog):
Pansin: Kung kailangan mo ng tulong sa wikang nagsasalita ka, serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad. Ipadala ang iyong kahilingan para sa tulong sa wika upang appeals@dhrm.virginia.gov~~V o fax sa 804-786-0356.