**BES - ACA Reconciliation Form**

**Section 1: Select ‘Addition’ to add a missing participant record or ‘Change’ to correct a participant record. Then, enter the participant identification.**

**🞏 ADDITION 🞏 CHANGE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Social Security Number: | |  | | | | | | | |
| Last Name: |  | | | Suffix: |  | First Name: |  | MI: |  |
| DHRM Group Number: | | Agency Code: |  | Group Code: | |  | Subdivision Code (TLC only): |  | |

**Section 2: Enter participant demographics when ‘ADDITION’ is selected.**

**Skip to Section 3 when ‘CHANGE’ is selected.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of Birth: |  | Gender M/F: | |  | | |
| Street or PO Box: |  | | | | | |
| City: |  | State: |  | | Zip+4: |  |

**Section 3: Enter the appropriate participant class and offer codes for each month using the values below. Be sure to put a hyphen in any month the participant is not in this group.**

|  |  |  |  |
| --- | --- | --- | --- |
| Class Codes: | | Offer Codes: | |
| FT | Full-time | Hyphen (-) | Not in this group |
| PT | Part-time | WP | New full-time participant not yet eligible for coverage in this group |
| R | Retiree |  | Note: New full-time participants should have a WP for the month in which |
| X | COBRA Qualified Beneficiary |  | they are hired. The WP changes to W when the participant becomes |
| XD | COBRA Qualified Beneficiary-Disability |  | eligible for coverage. See samples. |
| SS | Surviving Spouse | W | Participant is eligible for coverage but chose to waive enrollment |
| SC | Surviving Child |  | Note: New full-time and part-time participants should have a W for the |
| LS | Spouse in Split Medicare Contract |  | Month in which they become eligible for coverage. The W changes to E |
| LC | Child in Split Medicare Contract |  | When the participant enrolls in coverage. See samples. |
|  |  | E | Participant is enrolled in coverage |
|  |  |  | Note: The E changes to hyphen when the participant is no longer eligible |
|  |  |  | for coverage in this group. |
|  |  | F | Employer failed to offer coverage to ACA-eligible participant |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| <JAN> | | <FEB> | | <MAR> | | <APR> | | <MAY> | | <JUN> | |
| Class | Offer | Class | Offer | Class | Offer | Class | Offer | Class | Offer | Class | Offer |
|  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| <JUL> | | <AUG> | | <SEP> | | <OCT> | | <NOV> | | <DEC> | |
| Class | Offer | Class | Offer | Class | Offer | Class | Offer | Class | Offer | Class | Offer |
|  |  |  |  |  |  |  |  |  |  |  |  |

**Section 4: Employer’s Certification**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DHRM Group: | Agy: |  | Grp: |  | Sub: | |  |
| Signature: |  |  |  |  | Date Signed: | |  |
| Printed Name: |  |  |  | Phone: | ( ) - | Ext: |  |

**TLC:** Send authorized form by: Email: [TLC@dhrm.virginia.gov](mailto:TLC@dhrm.virginia.gov), Fax: (804) 786-1708, or Mail: DHRM-TLC, 101 N 14th St Fl 13, Richmond, VA 23219

**STATE:** Send authorized form by: Email: [OHB@dhrm.virginia.gov](mailto:OHB@dhrm.virginia.gov), Fax: (804) 371-0231, or Mail: DHRM-OHB, 101 N 14th St Fl 13, Richmond, VA 23219