Commonwealth of Virginia

State Health Benefits Program Enrollment Form For Retirees, Survivors And LTD Participants

INITIAL ENROLLMENT DEADLINES:

- New retirees or long-term disability participants must enroll within 31 days of their retirement or long-term disability start date (the day after the end of active coverage/eligibility.) Failure to enroll within that time limit will forfeit the only opportunity to enroll in retiree group coverage.
- Eligible survivors must enroll within 60 days of the date of the employee's, retiree's or LTD participant's death.

IMPORTANT!

- This form must be signed by the Enrollee (Retiree, Survivor or LTD participant). Forms signed by a dependent will not be accepted.
- Be sure to keep a copy of this form for documentation of your request for enrollment or change.
- Review your election(s) carefully. Once your election goes into effect, it may not be changed except as allowed under the policies of the Department of Human Resource Management. Retroactive plan changes are not allowed.

IF YOU ARE USING THIS FORM TO. . .	**COMPLETE PART(S) . . .**
• Enroll in plan that coordinates with Medicare	A, B, C, E
• Enroll in Non-Medicare State plan	A, B, D, E
• Enroll in *combination* of plans above	A, B, C, D, E
• Change plans and/or type of membership	A, B, C and/or D, E
• Make an Open Enrollment change (non-Medicare participant only)	A, B, D, E
• Waive or cancel participation in the State Health Benefits Program	F
• Waive existing coverage in VSDP/LTD due to open enrollment or a qualifying mid-year event, or cancel VSDP/LTD coverage	A, E
• Enroll in Extended Coverage/COBRA	Use your Election Form, part of your Election Notice.
• Change your address	A, E

IF YOU ARE A…	**SEND COMPLETED FORM TO . . .**
• New Retiree or New Survivor of Active State Employee • New VSDP or other LTD Participant	The Employing Agency's Benefits Administrator
• Current VRS Retiree or Survivor* • Current VSDP/LTD Participant* * *Including dependents who have separate plans from the Enrollee*	Virginia Retirement System P.O. Box 2500 Richmond, VA 23218-2500
• All Other Retirees, Survivors, or LTD Participants (Optional Retirement Plan, Local Retiree, etc.)	Your former Agency's Benefits Administrator

Part A. Enrollee Information – (Retiree, Survivor or LTD Participant Information Only – Not Dependent Information)

☐ Check here if this is an address change.

Social Security Number _____

Print Name _____ Health Plan Identification Number _____
(First) (M.I.) (Last)

Address _____ City _____ State _____ Zip + 4 _____

Day Time Phone (_____) _____

Birth Date _____/_____/_____ Sex: ☐ Male ☐ Female E-mail Address _____
Month Day Year

REASON FORM IS BEING SUBMITTED *(Check each appropriate category)*

☐ **Initial Enrollment.** *Check one:* ○ Retirement ○ VSDP LTD initial enrollment/waiver or other LTD initial enrollment
○ Survivor Enrollment ○ Re-enrolling from dependent status in active/other retiree coverage or from other active eligibility (Date losing other coverage_____)

☐ **Now Eligible For Medicare.** ○ Retiree/Survivor ○ Spouse ○ Child ○ VSDP or other LTD Participant

☐ **Open Enrollment (available to Non-Medicare Participants Only) To Change Plans And/Or Membership.**
○ Enrollee/Enrollee and Dependents ○ Dependent with Separate Coverage

☐ **Remove Dependent(s) From My Coverage.** (Change will be effective the first day of the month after this form is received.)

Name of Dependent(s) _____ Social Security or ID Number _____
If you are removing a dependent due to a qualifying mid-year event, please indicate the event below.

☐ **Medicare Eligible Member Making Allowable Plan Change.** (Effective date will be the first of the month after this form is received.)
○ Retiree/Survivor ○ Spouse ○ Child ○ VSDP or other LTD Participant

☐ **Cancel/Waive Coverage (go to Part F.).**

☐ **Qualifying Mid-Year Event.** Check the type of event below, and attach the appropriate supporting information as indicated. Please complete participant information in Part B. Submit this change within 60 days of the event. In most cases, the change will be effective the first day of the month following receipt of this form. Changes in membership due to these events allow non-Medicare participants to change plans. HIPAA Special Enrollments* allow the addition of all eligible dependents.

(Event if applicable/*Attach This Information)* **Date of Event** _____

Events That Are Consistent With Increasing Membership**

☐ Marriage/*Marriage Certificate**
☐ Birth or Adoption/*Birth Certificate or Adoption Agreement**
☐ Eligible dependent loses eligibility for Medicare, Medicaid or other government plan/*Government Documentation*
☐ Spouse or eligible child loses employer eligibility/ *Employer Documentation*
☐ Judgment, decree or order requiring coverage of an eligible child/*Court Order*
☐ Permanent custody granted/*Court Order*
☐ Spouse's, eligible child's or LTD participant's open enrollment or significant change under another employer's plan resulting in termination of coverage/*Employer Documentation to Support Change*
☐ Other HIPAA Special Enrollment *
__ LTD Participant/Dependent loses coverage for which they declined enrollment in this plan
__ Dependent loses coverage in Medicaid or the State Children's Health Insurance Program (CHIP)
__ Dependent becomes eligible for a Medicaid or CHIP premium assistance subsidy

Events That Are Consistent With Decreasing Membership

☐ Divorce/*Divorce Decree*
☐ Death of spouse or child/*Death Certificate*
☐ Child loses eligibility/*Documentation to Support*
☐ Judgment, decree or order to remove child/*Court Order*
☐ Covered dependent gains eligibility for Medicare or Medicaid/*Government Documentation*
☐ Spouse or covered child gains employer eligibility/ *Employer Documentation*
☐ Spouse or covered child's open enrollment or significant change under another employer's plan resulting in eligibility for coverage/ *Employer Documentation to Support Change*

Allows Plan Change

☐ Move affecting eligibility for Health Care Plan/*Benefits Administrator Validates Move*

*** You must provide documentation to support a membership addition. Your Benefits Administrator can provide additional information.*

TYPE OF MEMBERSHIP

Please select the membership type which describes the membership level for which you are enrolling:

☐ **Single Coverage** ☐ **Two people** ☐ **Family** – Enrollee with Two or More Dependents

VSDP/LTD Waive or Cancel for existing participants (See Part F. for new participants.):

☐ **VSDP/LTD Waiver of Health Coverage due to Open Enrollment, or a Qualifying Mid-Year Event** (indicate event on page 2)

☐ **VSDP/LTD Cancellation of Coverage without Open Enrollment or a Qualifying Mid-Year Event**

Part B. Enrollment

List all Medicare and Non-Medicare participants. Include yourself and everyone you are enrolling in a health plan (including all participants, not just additions or changes). Attach a copy of Medicare cards for all members who are Medicare-eligible.

Relationship Codes: E = Retiree, LTD or Survivor H = Husband W = Wife S = Son D = Daughter SS = Stepson SD = Stepdaughter O = Other child

NAME	Sex M/F	Birthday MM/DD/YYYY	Social Security Number	Relationship Code	Medicare Information (if applicable)		
					Medicare Claim No.	Part A Effective Date	Part B Effective Date

HEALTH BENEFITS PLAN SELECTION

Enrollees must select a plan based on their and their dependents' Medicare eligibility. Participants who are eligible for Medicare, regardless of age, must select a plan in Part C, and those who are not eligible for Medicare must select a plan in Part D. Enrollment in a Medicare-coordinating (Medicare is primary) plan must take place immediately upon any participant's eligibility for Medicare.

If you are making a plan change, you will only receive new ID cards that require updated information.

Part C. Plans For Retiree Group Participants Eligible For Medicare

If you are eligible for Medicare and have not enrolled in both Hospital Part A and Medical Part B of Medicare, contact your local Social Security Administration office. If you enroll in a plan that includes prescription drug coverage, you will be enrolled in Medicare Part D (pending approval by Medicare.) If you enroll in a Medicare Part D plan outside of the state program, you will be moved to Medical-Only coverage and may not return to the state program's Medicare Part D plan.

Please select a plan below and indicate whether the coverage is for you, your spouse, or a dependent child.

PLAN	COVERAGE FOR (check all that apply)			
☐ **Advantage 65 (A65)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
☐ **Advantage 65 with Dental/Vision (65DV)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
☐ **Advantage 65 – Medical Only* (65MO)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
☐ **Advantage 65 – Medical Only* with Dental/Vision (MODV)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child

**** Does not include coverage for outpatient prescription drugs.***

(Part C. continues on page 4)

The plans below may be selected only by members currently enrolled in Option I/Medicare Complementary, or Option II/Medicare Supplemental.

PLAN	COVERAGE FOR (check all that apply)
☐ **Option I (B1)**	☐ Retiree/Survivor ☐ Spouse ☐ Child
☐ **Option II (B2)**	☐ Retiree/Survivor ☐ Spouse ☐ Child
☐ **Option II with Dental/Vision (B2DV)**	☐ Retiree/Survivor ☐ Spouse ☐ Child

Dental/Vision coverage may be added to either Advantage 65, Advantage 65 – Medical Only, or Option II at any time, and it may be cancelled at any time. However, once the Dental/Vision option has been elected and cancelled one time in any Medicare-coordinating plan, it may not be elected again. Participants in Option I or Option II may enroll in Advantage 65 (including Advantage 65 – Medical Only) at any time. However, once enrolled in any Advantage 65 plan, neither Option I nor Option II may be elected again. Except for initial enrollment in a Medicare-coordinating plan, these elections/changes are effective the first of the month following receipt of your request.

Part D. Plans For Retiree Group Participants Not Eligible For Medicare

All non-Medicare family members must enroll in the same plan.

STATEWIDE HEALTH PLANS

- ☐ COVA Care (with preventive dental) (ACC0)
- ☐ COVA Care + Out of Network (ACC1)
- ☐ COVA Care + Expanded Dental (ACC2)
- ☐ COVA Care + Out of Network and Expanded Dental (ACC3)
- ☐ COVA Care + Expanded Dental + Vision & Hearing (ACC4)
- ☐ COVA Care + Out of Network + Expanded Dental + Vision & Hearing (ACC5)
- ☐ COVA HealthAware (with preventive dental) (CHA)
- ☐ COVA HealthAware + Expanded Dental (CHA2)
- ☐ COVA HealthAware + Expanded Dental & Vision (CHA1)
- ☐ COVA HDHP - High Deductible Plan (with preventive dental) (CHD)
- ☐ COVA HDHP - High Deductible Plan + Expanded Dental (CHD1)
- ☐ TRICARE Supplement (TRC)
  DEERS # _____ (required)

REGIONAL HEALTH PLAN

- ☐ Kaiser Permanente HMO- available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP)

Part E. Authorization, Enrollee Statement, And Certification

ENROLLEE STATEMENT: I want to enroll or make an allowable change in the Retiree Health Benefits Program. The cost of coverage will be deducted from my Virginia Retirement System (VRS) retirement benefit. If I am not receiving a VRS monthly benefit, or if my VRS monthly benefit will not accommodate my health insurance premium, I will be billed directly. To cancel coverage, I must send my request in writing to the appropriate recipient noted on page 1. Cancellation of coverage will be effective the end of the month in which my written request is received. I understand that notice of cancellation does not relieve me from payment for monthly coverage that has already begun. I understand that if I cancel my state retiree coverage, I will not have another opportunity to enroll in the Retiree Health Benefits Program, and that cancellation of prescription drug and/or Dental/Vision benefits will preclude any future enrollment for those benefits. I understand that my health premiums are subject to change. I am aware that the Commonwealth of Virginia reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that failure to pay premiums by the date designated on my monthly bill, if applicable, will result in cancellation of coverage and will permanently revoke my eligibility for the program. Further, I understand that claims may not be processed for services during months for which premium payment in full has not been received. I understand that enrolling or maintaining coverage for ineligible dependents may result in removal from the State Retiree Health Benefits Program for up to three years.

CERTIFICATION/AUTHORIZATION: I certify that I understand the State Retiree Health Benefits Program eligibility criteria and agree to abide by all participation requirements. I certify that all dependents listed meet the eligibility requirement of the program and that the information I have provided on this form is complete and accurate to the best of my knowledge. I understand that intentionally giving incorrect information is considered perjury and punishable to the fullest extent of the law. I understand that the health plan and its business associates have the right to use protected health information in connection with the treatment, payment and health plan operations allowed for by HIPAA.

Enrollee's Signature[1] _____ **Date** _____

Print Name _____

[1]*Dependents are not authorized to sign this form. It must be signed by the Retiree, Survivor or LTD Participant.*

Part F. To Waive Or Cancel State Coverage

RETIREES AND/OR SURVIVORS

Name _____ Effective Date or Terminate Date _____
(First) (M.I.) (Last) (MM/DD/YYYY)

Social Security Number _____ Telephone Number _____

WAIVE COVERAGE

☐ **I am a retiree and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree coverage only within 31 days of that event.

Spouse's Name _____ Spouse's Social Security Number _____

CANCEL/DECLINE COVERAGE

☐ **I am a new retiree* and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll except as allowed in **WAIVE COVERAGE** section.
**Includes retirees ending their 12-month severance benefit period.*

☐ **I am a current retiree/survivor and wish to cancel my coverage in the State Health Benefits Program for retirees.** I understand that neither I nor my dependents will be permitted to re-enroll in the program at any time. This serves as my written notification and authorization to cancel my coverage and that of my dependents. This will be effective the first of the month after notice is received.

☐ **I am a retiree or survivor who has become eligible for coverage in an active state plan and I wish to cancel my retiree coverage.** I understand that I may re-enroll in the retiree program within 31 days of the loss of active coverage and that I must have maintained continuous coverage in the State program to do so unless I become newly eligible for retiree coverage.

If you are entitled to a Health Insurance Credit, waiving or canceling State coverage in no way affects your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

NEW VSDP/LTD PARTICIPANTS

Name _____ Effective Date _____
(First) (M.I.) (Last)

Social Security Number _____ Telephone Number _____

WAIVE COVERAGE AT START OF LTD (For waiver or cancellation of existing LTD coverage due to State Open Enrollment or a qualifying mid-year event, return to part A.)

☐ **I am a new VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll unless I experience a qualifying mid-year event or Open Enrollment. (Open Enrollment is available to non-Medicare participants only).

☐ **I am a VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree group coverage only within 31 days of that event.

Spouse's Name _____ Spouse's Social Security Number _____

If you are entitled to a Health Insurance Credit, waiving or canceling coverage does not affect your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

Agency Approval/Agency Use Only

I understand that the agency Benefits Administrator is responsible for the initial setup of the retiree's, active survivor's or VSDP/LTD participant's record in the Benefits Eligibility System (BES). The agency Benefits Administrator is also responsible for forwarding a copy of the completed enrollment form to the retiree group Benefits Administrator (e.g., VRS).

Agency Name _____ Agency Number _____ Coverage Effective Date _____

I have reviewed this form, and verified that the retiree, survivor or LTD participant is eligible for the plan or waiver selected. I certify that the information on this form is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date _____

Print Name and Title _____ Phone Number _____

This participant is enrolling as:

☐ Virginia Retirement System Retiree/Survivor ☐ Local Retiree/Survivor

☐ ORP Retiree/Survivor (name of ORP Vendor) _____

☐ VSDP/LTD Participant ☐ Other LTD Participant ☐ Non-Annuitant Survivor

The participant has been told that the first premium would be in the amount of $ _____

If retiring, indicate type of retirement: ☐ Service Retirement ☐ Disability Retirement Retirement Date: _____

VRS Use Only (For Existing Retiree Group Members)

Date Form Received _____ Effective Date of Change (subject to DHRM approval) _____

For Disability Retirees:

Date of Approval Letter _____ Date of Retirement _____