



State Health Benefits Program Active Employee Eligibility and Enrollment Form

Overview

The following is a general description of the Commonwealth of Virginia's State Health Benefits Program eligibility and enrollment information for employees. It is not intended to replace member handbooks and other plan documents. For more detailed information or clarification, visit the DHRM Web Site at www.dhrm.virginia.gov or contact your Benefits Administrator. Participation in the State Health Benefits Program is subject to current program provisions, state and federal laws and regulations, and plan availability. The Commonwealth reserves the right to change your enrollment to ensure compliance.

When Can I Request Enrollment or Election Changes?

When Newly Eligible

For health care coverage and flexible reimbursement accounts, request enrollment within 30 days of the date of hire or of becoming eligible.

During Open Enrollment

The Open Enrollment period occurs each spring and is your annual opportunity to enroll or make election changes to health care coverage and to enroll in FRAs effective July 1.

Qualifying Mid-Year Events

Certain qualifying mid-year events permit specific election changes outside the Open Enrollment period, including changes to your plan and membership. Examples of qualifying mid-year events include changes in your employment, changes in your marital status, changes in the number of your eligible family members, and changes affecting the employment of a covered family member. Your change request must be received within 60 days of the event and be on account of and consistent with the event. You will be asked to provide supporting documentation. *A complete list of qualifying mid-year events may be found on the DHRM Web site and on the attached enrollment form.*

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, under a *HIPAA Special Enrollment* you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

There are two additional circumstances under the Health Insurance Portability and Accountability Act (HIPAA) that will permit you to enroll. You may enroll when:

- You or your dependent lose coverage in Medicaid or the State Children's Health Insurance Program (CHIP) and you request coverage under the plan within 60 days of the time your coverage ends; or
- You or your dependent become eligible for a Medicaid or CHIP premium assistance subsidy and you request coverage under the plan within 60 days after your eligibility is determined.

To request a *HIPAA Special Enrollment* or obtain more information, contact your agency's Benefits Administrator.

What Election Choices are Available?

Health Care Coverage in most cases includes medical, dental, pharmacy, and behavioral health services. Certain family members who meet eligibility and rules requirements may also be covered. Supporting documentation must be provided before family members can be added.

- Employees who enroll or fail to remove a family member who is not eligible for coverage may face disciplinary action and removal from the State Health Benefits Program for up to three years.
- Continued coverage is available for you and covered family members who lose eligibility under the State Health Benefits Program. More information about Extended Coverage (COBRA) is available on the DHRM Web Site or from your Benefits Administrator. Portability information for the TRICARE supplement is available from the plan administrator.
- Health Care Premiums are subject to change every July 1.
- Payroll-deducted premiums are withheld on a pre-tax basis.
- Employees are obligated to pay for any month of health care coverage already begun.
- Failure to pay the premium owed results in cancellation of coverage and forfeiture of any partial payment.

Flexible Reimbursement Accounts allow you to set aside part of your salary each pay period before taxes for eligible medical or dependent care expenses. There is a monthly pre-tax administrative fee for one or both accounts. For more information, visit the DHRM Web site or contact your agency Benefits Administrator.

- A flexible reimbursement account must only be used to pay for IRS-qualified expenses and only for IRS-eligible dependents.
- Enrollees must exhaust all other sources of reimbursement (including those provided under an employer's plans) before seeking reimbursement from a flexible reimbursement account. They may not seek reimbursement through any other source.
- Enrollees must collect and maintain sufficient documentation to validate reimbursement from a flexible reimbursement account.

Eligibility Definitions and Required Documentation

Dependents	Eligibility Definition	Documentation Required
Spouse	The marriage must be recognized as legal in the Commonwealth of Virginia. Note: Ex-spouses will not be eligible, even with a court order.	<ul style="list-style-type: none"> • Photocopy of marriage certificate, and • Photocopy of the top portion of the first page of the employee's most recent Federal Tax Return that shows the dependent listed as "Spouse." NOTE: All financial information and Social Security Numbers can be redacted.
Natural or Adopted Son/ Daughter	A son or daughter may be covered to the end of the year in which he or she turns age 26	<ul style="list-style-type: none"> • Photocopy of birth certificate or legal adoptive agreement showing employee's name. (Note: If this is a legal pre-adoptive agreement, it must be reviewed and approved by the Office of Health Benefits.)
Stepson or Stepdaughter	A stepson or stepdaughter may be covered to the end of the year in which he or she turns age 26	<ul style="list-style-type: none"> • Photocopy of birth certificate (or adoption agreement) showing the name of the employee's spouse; and • Photocopy of marriage certificate showing the employee and dependent parent's name and • Photocopy of the most recent Federal Tax Return that shows the dependent's parent listed as "Spouse." NOTE: All financial information and Social Security Numbers can be redacted.
Other Female or Male Child	An unmarried child in which a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody may be covered until the end of the year in which he or she turns age 26 if: <ul style="list-style-type: none"> • the principal place of residence is with the employee; • they are a member of the employee's household; • they receive over one-half of their support from the employee and • the custody was awarded prior to the child's 18th birthday. 	<ul style="list-style-type: none"> • Photocopy of birth certificate and • Photocopy of the Final Court Order granting permanent custody with presiding judge's signature.

State Health Benefits Program Enrollment Form For Employees

Review each section and carefully PRINT your enrollment information.

Section 1: Personal Information

Name _____ Identification Number _____
Last Name First Name M.I. Assigned ID or Social Security Number

Date of Birth _____ Gender: Male Female
Month/Day/Year

Important! If your address has changed, be sure to verify the correct format at <http://zip4.usps.com/zip4/welcome.jsp>.

Street Address _____ P.O. Box _____

City _____ State _____ Zip + 4 _____

State E-mail: _____ Personal E-mail: _____

State Phone: (_____) _____ Personal Phone: (_____) _____

Section 2: Reason For This Enrollment or Election Change Request

Please check one box.

- Initial Enrollment for Newly Eligible Employee:** _____ (01)
Month/Day/Year
- Open Enrollment** (56)
- Add to Existing Family Membership/Documentation to Support Eligibility** (19)

QUALIFYING MID-YEAR EVENT/ATTACH THIS DOCUMENTATION FROM THE LIST OF EVENTS BELOW: _____
Month/Day/Year

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Birth or Adoption/<i>Birth Certificate or Adoption Agreement</i> (15) <input type="checkbox"/> Child Covered Under Your Plan Lost Eligibility/<i>Documentation to Support</i> (38) <input type="checkbox"/> Death of Child/<i>Documentation Validating Death</i> (17) <input type="checkbox"/> Death of Spouse/<i>Documentation Validating Death</i> (08) <input type="checkbox"/> Dependent Care Cost or Coverage Change/<i>Documentation from Dependent Care Provider</i> (61) <input type="checkbox"/> Divorce/<i>Divorce Decree</i> (10) <input type="checkbox"/> Employment Change – Full-time to Part-time/<i>Agency Validates Employment Change</i> (77) <input type="checkbox"/> Employment Change – Part-time to Full-time/<i>Agency Validates Employment Change</i> (78) <input type="checkbox"/> Employment Change – Unpaid Leave of Absence Began/<i>Agency Validates Leave</i> (49) <input type="checkbox"/> Employment Change – Unpaid Leave of Absence Ended/<i>Agency Validates Leave</i> (50) <input type="checkbox"/> Gained Eligibility Under Medicare or Medicaid/<i>Government Documentation</i> (66) | <ul style="list-style-type: none"> <input type="checkbox"/> HIPAA Special Enrollment/<i>HIPAA Certificate</i> (70) <input type="checkbox"/> Judgment, Decree or Order to Add Child/<i>Court Order</i> (71) <input type="checkbox"/> Judgment, Decree or Order to Remove Child/<i>Court Order</i> (67) <input type="checkbox"/> Lost Eligibility Under Governmental Plan/<i>Government Documentation</i> (76) <input type="checkbox"/> Lost Eligibility Under Medicare or Medicaid/<i>Government Documentation</i> (09) <input type="checkbox"/> Marriage/<i>Marriage Certificate</i> (07) <input type="checkbox"/> Move Affecting Eligibility for Health Care Plan/<i>Agency Validates Move</i> (05) <input type="checkbox"/> Other Employer's Open Enrollment or Plan Change/<i>Employer Documentation</i> (62) <input type="checkbox"/> Spouse or Child Gained Eligibility under Their Employer's Plan/<i>Employer Documentation</i> (28) <input type="checkbox"/> Spouse or Child Lost Eligibility under Their Employer's Plan/<i>Employer Documentation</i> (13) |
|---|--|

**The numbers in parentheses are for agency use.*

Section 3: Flexible Reimbursement Accounts Election

To enroll in or change an FRA, enter the amount you wish deducted each pay period. For assistance in determining your pay period election, complete the FRA worksheet available on the DHRM Web site at www.dhrm.virginia.gov or from your Benefits Administrator.

I do not wish to participate in an FRA.

MEDICAL FLEXIBLE REIMBURSEMENT ACCOUNT	
For eligible medical expenses incurred by you, your spouse and eligible dependents. (Minimum is \$10 per pay period; Maximum allowable contribution is up to \$5,000.)	
Amount per regular paycheck (Whole dollar amounts only)	= _____

DEPENDENT CARE FLEXIBLE REIMBURSEMENT ACCOUNT	
For eligible dependent care expenses incurred by you, your spouse and eligible dependents. (Minimum is \$10 per pay period; Maximum allowable contribution is up to \$5,000 depending on your tax filing status.)	
Amount per regular paycheck (Whole dollar amounts only)	= _____

Section 4: Health Care Coverage Election

Check the one that applies. The letters in parentheses are for agency use.

I do not wish to participate in health care coverage (W)

No change to my current plan year election for health care coverage

Health Plans

- | | |
|---|---|
| <input type="checkbox"/> COVA Care* (with basic dental) (ACC0) | <input type="checkbox"/> COVA Connect** (with basic dental) (OCC0) |
| <input type="checkbox"/> COVA Care + Out-of-Network (ACC1) | <input type="checkbox"/> COVA Connect + Out-of-Network (OCC1) |
| <input type="checkbox"/> COVA Care + Expanded Dental (ACC2) | <input type="checkbox"/> COVA Connect + Expanded Dental (OCC2) |
| <input type="checkbox"/> COVA Care + Out-of-Network + Expanded Dental (ACC3) | <input type="checkbox"/> COVA Connect + Out-of-Network + Expanded Dental (OCC3) |
| <input type="checkbox"/> COVA Care + Expanded Dental + Vision & Hearing (ACC4) | <input type="checkbox"/> COVA Connect + Expanded Dental + Vision & Hearing (OCC4) |
| <input type="checkbox"/> COVA Care + Out-of-Network + Expanded Dental + Vision & Hearing (ACC5) | <input type="checkbox"/> COVA Connect + Out-of-Network + Expanded Dental + Vision & Hearing (OCC5) |
| <input type="checkbox"/> COVA HDHP – High Deductible Health Plan (CHD) – available statewide | <input type="checkbox"/> Kaiser Permanente HMO – available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP) |
- TRICARE Supplement DEERS # _____ (required)

* COVA Care available in all areas except designated Hampton Roads zip codes

** COVA Connect available in designated Hampton Roads zip codes

Please check one box.

I wish to cover the following eligible family members listed below. You will be required to submit documentation when adding family members to your coverage. **Any family member not listed will not be covered.**

I do not wish to cover any family members.

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF=other female child OM=other male child

RELATIONSHIP CODE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY NUMBER
Spouse					
Children					

Section 5: Employee Certification and Authorization

I certify that I have reviewed and understand the State Health Benefits Program eligibility and enrollment information and I agree to abide by all participation requirements. I certify that all dependents listed meet the eligibility requirements 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.

Print Your Name _____ Assigned ID or Social Security Number _____

Sign Here _____ Date _____

Section 6: Agency Verification and Approval

Date Received _____ Date Keyed _____ BES Effective Date _____
Month/Day/Year Month/Day/Year Month/Day/Year

Print Contact Name _____ Phone _____ Agency/Group Number _____/_____

Important: The daily Agency Transaction Turnaround document is the official record of this change. It is your responsibility to review and confirm this document to ensure that changes made are accurate.