State Health Benefits Program Enrollment Form For Employees

Review each section and carefully PRINT your enrollment information. For state health benefits eligibility information, visit the DHRM website at www.dhrm.virginia.gov or contact your Benefits Administrator.

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! *Be sure to verify the correct format of your address 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: (_____) _____ ☐ Mobile

Section 2: Reason For This Enrollment or Election Change Request

Check the box that applies. The numbers in parentheses are for agency use.

☐ **Open Enrollment** (56)

☐ **Initial Enrollment for Newly Eligible Employee:** _____ (01)
MONTH/DAY/YEAR

☐ **Qualifying Mid-Year Event/*Documentation to Support the Event***

Check the type of event below, and attach the appropriate supporting documentation as indicated. Date of Event: _____
MONTH/DAY/YEAR

Events consistent with adding family members to coverage:

☐ Marriage (certified marriage certificate) (07)
☐ Birth or Adoption (birth certificate/hospital announcement or adoption agreement) (15)
☐ Judgment, Decree, or Order to Add Child (court order) (71)
☐ Lost eligibility Under Governmental Plan (government documentation) (76)
☐ Lost eligibility Under Medicare or Medicaid (government documentation) (09)
☐ Spouse or Child Lost Eligibility Under Their Employers Plan (employer documentation) (13)

Events consistent with removing family members from coverage:

☐ Divorce (divorce decree) (10)
☐ Death of Spouse (documentation validating death) (08)
☐ Death of Child (documentation validating death) (17)
☐ Child Covered Under Plan Lost Eligibility (documentation to support) (38)
☐ Judgment, Decree or Order to Remove Child (court order) (67)
☐ Gained Eligibility Under Medicare or Medicaid (government documentation) (66)
☐ Spouse or Child Gained Eligibility Under Their Employers Plan (employer documentation) (28)

Other events:

☐ Employment Change: ☐ Full-time to Part-time (77) ☐ Part-time to Full-time (78)
☐ Unpaid Leave Began (49)
☐ Unpaid Leave Ended (50)
☐ Dependent Care Cost or Coverage Change (documentation from dependent care provider) (61)
☐ HIPAA Special Enrollment Due to Loss of Other Coverage (HIPAA certificate) (70)
☐ Move Affecting Eligibility for Health Care Plan (agency validates move) (05)
☐ Other Employers Open Enrollment or Plan Change (employer documentation) (62)
☐ Enrollment in a Marketplace Exchange Health Plan (Documentation of the Marketplace coverage enrollment and the effective date of coverage)

☐ **Add to existing Family Membership (documentation to support eligibility) (19)**

Section 3: Flexible Spending Accounts Election – You Must Enroll Every Plan Year

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

☐ **I do not wish to participate in an FSA.**

HEALTH FLEXIBLE SPENDING 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 $2,750.)

Amount per regular paycheck (Whole dollar amounts only) = _____

DEPENDENT CARE FLEXIBLE SPENDING 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) = _____

A10459 (3/2020)

TEAR OFF AT PERFORATION

Section 4: Health Care Coverage Election

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

☐ No change to my current health plan selection and family members/membership level

(If you check either box above proceed to Section 5.)

A. Health Plan Selection – Check the box that applies

☐ No change to my current health care plan

STATEWIDE HEALTH PLANS

Administered by Anthem Blue Cross Blue Shield*

☐ COVA Care (with preventive dental) (ACCO)
☐ 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 HDHP- High Deductible Plan (with preventive dental) (CHD)
☐ COVA HDHP- High Deductible Plan + Expanded Dental (CHD1)

Administered by Aetna*

☐ COVA HealthAware (with preventive dental) (CHA)
☐ COVA HealthAware + Expanded Dental (CHA2)
☐ COVA HealthAware + Expanded Dental & Vision (CHA1)

Administered by Selman & Company

☐ TRICARE Supplement (TRC)
DEERS # _____ (required)

*Anthem Pharmacy delivered by IngenioRx administers pharmacy benefits. Delta Dental administers dental benefits.

REGIONAL HEALTH PLANS

Administered by Kaiser Permanente of the Mid-Atlantic States, Inc.

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

Administered by Optima

☐ Optima Health HMO – available primarily in Hampton Roads zip codes (OHP)

B. Family Members – Check the box that applies

☐ No change to my existing covered family members

☐ I do not wish to cover any family members

☐ I wish to cover the eligible family members listed below. ***(Note: you will be required to submit documentation when adding family members to your coverage.)***

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

**Relationship Codes: SM=spouse male SF=spouse female S=son D=daughter SS=stepson SD=stepdaughter OF=other female child OM=other male child

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. I understand that participating in a Flexible Spending Account (FSA) is completely voluntary, and that payments from my FSA are independently reviewed for compliance with IRS regulations. I further understand that the IRS requires me to reimburse the Plan for any improper, erroneous or excess reimbursement amount that I do not resolve within the timeframe provided by the Plan. In accordance with §40.1-29(C) of the Code of Virginia, by enrolling in an FSA I specifically authorize the Commonwealth of Virginia to withhold from my paycheck on a post-tax basis such amounts as are necessary to replenish my FSA for any improper, erroneous or excess reimbursement.

Print Your Name _____ Assigned ID or Social Security Number _____

Sign Here _____ Date _____

Section 6: Agency Verification and Approval

Date Received _____ (Month/Day/Year) Date Keyed _____ (Month/Day/Year) BES Effective Date _____ (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.

TEAR OFF AT PERFORATION