Elective Group Health Plan
Opt-in Change/Request for Termination

Each self-funded group health plan specified in § 38.2-3445.06 A of the Code of Virginia and self-funded coverage specified in § 38.2-3445.06 C of the Code of Virginia may opt-in to the balance billing and arbitration requirements set forth in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia. Such a plan is known as an "elective group health plan." Each elective group health plan may opt-in to the balance billing and arbitration requirements set forth in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia.

To change opt-in information, to terminate from the opt-in, or make a change to previously submitted information, complete and submit the form as follows:

- **To change opt-in information**, please complete this form, identifying the updated information. If this form contains updated information, please sign the attestation and check here: ☐
- **To terminate from the opt-in or make a change to previously submitted information, complete** and **submit this form electronically** to the Virginia State Corporation Commission Bureau of Insurance at BBVA@scc.virginia.gov for each affected health plan offered by the sponsor with a unique Group Identification Number.

This form must be submitted at least **30 days in advance** of the election to terminate, and as soon as possible to identify a change. The effective date for termination must be **December 31** of any year or the **last day of the group health plan's plan year.**

Elective Group Health Plan Information

Health Plan Name: _____

(☐Check here if changed and provide previous name) _____

Number of covered lives in Virginia enrolled in your plan: _____

Group Identification Number: _____

(☐Check here if changed and provide previous number) _____

Employer/Sponsor Name: _____

(☐Check here if changed and provide previous name) _____

Address: _____ *(☐Check here if changed)*

City: _____ State: _____ Zip: _____

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Designated contact name for inquiries: _____ *(☐Check here if changed)*

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Opt-in duration:

☐ One year *(☐Check here if changed)*

☐ Automatic renewal (continuous until terminated by providing notice with this form at least 30 days prior to the end of a calendar year or plan year) *(☐Check here if changed)*

Opt-in effective date:_____ *(☐Check here if changed)*

Opt-in Termination effective date:_____ *(☐Check here if changed)*

Your Contact Information (person completing the form)

Name: _____ *(☐Check here if changed)*

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Are you a third-party administrator ("TPA") of an elective group health plan? ☐Yes ☐ No

If Yes, skip to the TPA Information section below.

The TPA must be notified of the decisions identified on this form.

Please provide the name of person contacted at the TPA: _____

Contact was made by: ☐ phone ☐ email ☐ other (explain) _____

Third-party Administrator Information

*If you self-administer, please include your own information.

Administrator Name: _____

(☐Check here if changed and provide previous name) _____

Address: _____ *(☐Check here if changed)*

City: _____ State: _____ Zip: _____

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Name of designated contact for inquiries: _____ *(☐Check here if changed)*

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Elective Group Health Plan Opt-in Attestation for Changes

CERTIFICATION:

By submission of this form, _____ (name of employer/sponsor) requests the changes noted above related to _____ (name of health plan) that participates in and is bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules. _____ (name of employer/sponsor) consents to have the information included in this updated information, as applicable, appear in the directory of elective group health plans posted on the website of the State Corporation Commission Bureau of Insurance.

I, _____ (name of authorized representative), attest that I have been designated by _____ (employer/sponsor name) to act on behalf of _____ (name of health plan) to request these changes.

Signature _____

Title _____

Date _____

Elective Group Health Plan Opt-in Termination Attestation

CERTIFICATION:

By submission of this form, _____ (name of employer/sponsor) hereby elects to end participation of _____ (name of health plan) in the program afforded by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules. This provides the State Corporation Commission Bureau of Insurance the authority to remove group health plan information from the directory of elective group health plans posted on the website of the State Corporation Commission Bureau of Insurance.

I, _____ (name of authorized representative), attest that I have been designated by _____ (employer/sponsor) to submit the termination of _____ (name of health plan) for participation in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules.

Signature _____

Title _____

Date _____