# Commonwealth of Virginia
# Health Benefits Program Application

This application must be used by local employers to apply for coverage under The Local Choice Health Benefits Program sponsored by the Commonwealth of Virginia. **An Executive signature** is required in order for The Local Choice to release rate information. This document will define how your plan is administered if The Local Choice is selected. Please complete carefully and fully.

YOUR CURRENT HEALTH CARE COVERAGE SHOULD NOT BE TERMINATED UNTIL THIS APPLICATION AND AN ADOPTION AGREEMENT HAVE BEEN APPROVED AND ACCEPTED IN WRITING BY THE COMMONWEALTH OF VIRGINIA.

Today's Date: _____

## I. GENERAL INFORMATION

1. Full name of local employer _____

   Type of group *(check both if applicable)*
   ☐ Local government ☐ School district ☐ Other (Please attach enabling legislation): _____

2. Street Address _____
   Mailing Address/P.O. Box _____
   City _____ State _____ Zip Code _____

3. Plan administration Executive Correspondent *(This person will receive renewal and contractual information.)*
   Name _____ Telephone Number _____
   Title _____ Fax Number _____
   E-mail Address _____
   Address (if different from item 2. above) _____

4. Group Benefits Administrator (This person will receive routine plan administration materials.)
   Name _____ Telephone Number _____
   Title _____ Fax Number _____
   E-mail Address _____
   Address *(if different from item 2. above)* _____

5. Has your group previously participated in The Local Choice Health Benefits Program? ☐ No ☐ Yes – From _____ *month/year* to _____ *month/year*.

6. Proposed plan effective date: Month _____ Day _____ Year _____

7. **Applicable only for employers who offer no health care coverage to their employees** and whose employees elect to individually join the Health Benefits Program.

   It is hereby certified that _____ (the Employer) offers no health care plan to employees. The Employer will, on behalf of employees who elect to individually join the Program, collect and remit premiums and assist the Department of Human Resource Management as necessary.

   By: _____
   *(Name)* *(Title)* *(Local Employer)*

   *(These Employers do not need to complete Section IV.)*

## II. ELIGIBILITY REQUIREMENTS

1. Define permanent **full-time** employees to be **eligible** for coverage. _____

2. Will your **elected officials** be eligible? If yes, as ☐ full-time or ☐ part-time?

3. Are permanent **part-time** employees (20 hours or more per week) to be **eligible**? ☐ Yes ☐ No
   If yes, please define limitations: _____

4. Are dependents to be offered coverage? ☐ Yes ☐ No
   If yes, eligibility requirements will be outlined in benefits material.

5. Do you want to cover dependents of deceased employees until the end of the month following the employee's death? If so, full premium is required and no plan changes are permitted. ☐ Yes ☐ No

6. Are retirees to be offered coverage? ☐ Yes ☐ No
   *Note: Elected officials are not eligible for Retiree coverage.*
   If yes, please explain terms and conditions including definition of retiree eligibility._____

7. Please describe any employees or classes of employees to be specifically excluded from coverage. _____

8. Please specify whether the eligibility information in this section differs in any way from the eligibility criteria for your current health benefits program. _____

## III. CONTRIBUTION REQUIREMENTS

**TLC Minimum Employer Contributions:**

- Full-Time: 80% of average single cost
- No employer contribution is required for dependents if more than 75% of eligible employees enroll
- If less than 75% enroll, the employer must pay at least 20% of the cost of Dependent Coverage
- If Part-Time coverage is offered the employer must pay a minimum of 50% of the amount contributed toward Full Time employee coverage at all membership levels
- HDHP contributions are calculated separately from other contribution calculations
  – Minimum employer contributions for HDHP are 80% F/T single employee cost and 20% of dependent cost
- Higher contributions are permitted and encouraged
- No contributions are required for retirees but are encouraged

1. Will employees be required to contribute to obtain employee coverage? ☐ Yes ☐ No
   If yes, please list the amounts of employer and employee contributions:

2. Will employees be required to contribute to obtain dependent coverage? ☐ Yes ☐ No
   If yes, please list the amounts of employer and employee contributions:

3. Do you offer employees a Section 125 pre-tax premium program? ☐ Yes ☐ No
   *Note: Cafeteria plan limitations will apply.*

4. Will retirees be required to contribute to obtain retiree coverage? ☐ Yes ☐ No
   If yes, please list the amounts of employer and retiree contributions:

5. Will retirees be required to contribute to obtain dependent coverage? ☐ Yes ☐ No
   If yes, please list the amounts of employer and retiree contributions:

## IV. FINANCIAL AND STATISTICAL INFORMATION

**• Please Complete For All Current Health Benefits Plan(s) Offered By Your Group:**

1. Provide current carrier(s), policy number(s), name and type of plan (HMO, PPO, POS, indemnity, etc):

Name_____ Policy #_____ Type Plan_____

Name_____ Policy #_____ Type Plan_____

Name_____ Policy #_____ Type Plan_____

2. Provide a benefit plan booklet or certificate outlining the current health benefits plan(s), and note any recent changes for each of the plans maintained by your group.

3. Please list your rate history and claims "experience" (if available) for the past three years. Rate history is required.
☐ Information Attached

_____

4. Please attach, if applicable, a full explanation of any special financial arrangements such as fully insured, Administrative Services Only (ASO), holding reserve funds, aggregate stop loss, deficit recovery agreements, minimum premium, etc. that are in effect.
☐ Information Attached

_____

## V. PLAN DEMOGRAPHICS

**Do you currently have group coverage with Anthem Blue Cross and Blue Shield?** ☐ Yes ☐ No
If yes, you do not need to submit financial or statistical information. However, we must have your signature to authorize release of this information from Anthem so that we can establish rates for the benefit plans requested.

**Signature** _____ **Title**_____

**Print Name**_____

1. Provide current census information about eligible employees/retirees for each benefit plan offered to include the details listed below. You may use the chart provided in item 4, attach the information in a separate report, or send it electronically to **tlc@dhrm.virginia.gov. All groups, please complete items 2 and 3.**

- Coverage category (active, retiree, COBRA, all other employees)
- Employee identification number
- Gender and date of birth
- Type of membership (Employee Only, Employee and One Dependent, Family or waived status)
- Job classification (regular full-time or regular part-time)

**2. NUMBER OF TOTAL ELIGIBLE EMPLOYEES _____**

Number of Active Employee Participants_____ Number of Retiree Participants NOT Eligible for Medicare _____

Number of COBRA Participants _____ Number of Retiree Participants Eligible for Medicare_____

4. Complete the charts to show the demographic make-up of your group, attach the data in a separate report, or transmit electronically to tlc@dhrm.virginia.gov. Only needed if not currently covered by Anthem.

**ACTIVE COVERAGE**

| | Number Of Employee Only | | Number Of Employee Plus One Dependent | | Number Of Family | |
|---|---|---|---|---|---|---|
| Age Range | Male | Female | Male | Female | Male | Female |
| 0-29 | | | | | | |
| 30-39 | | | | | | |
| 40-44 | | | | | | |
| 45-49 | | | | | | |
| 50-54 | | | | | | |
| 55-59 | | | | | | |
| 60-64 | | | | | | |
| Over 65 | | | | | | |
| *Total* | | | | | | |

**RETIREE COVERAGE**

| | Number Of Retiree Only | | Number Of Retiree Plus One Dependent | | Number Of Retiree Plus Family | |
|---|---|---|---|---|---|---|
| Age Range | Male | Female | Male | Female | Male | Female |
| 0-55 | | | | | | |
| 56-59 | | | | | | |
| 60-64 | | | | | | |
| 65-69 | | | | | | |
| 70-74 | | | | | | |
| 75-79 | | | | | | |
| Over 80 | | | | | | |
| *Total* | | | | | | |

**VI. CERTIFICATION (Signature Required)**

I certify that the information supplied by me on this application is accurate to the best of my knowledge.

Signature _____ Title_____

Print Name _____

Application prepared by (please print) _____
*(Name)* *(Title)* *(Date)*

Telephone number (_____) _____ Fax number (_____) _____

E-mail Address _____

**TLC gives you the option of a printed or electronic proposal. Please select one of the following:**

☐ Printed ☐ Electronic

**Forward this completed application to:**

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
(804) 786-6460
E-mail: tlc@dhrm.virginia.gov
Web: www.thelocalchoice.virginia.gov *(This form is available on the Web site.)*

T20445 (R1/2013)