Commonwealth of Virginia
Department of Human Resource Management

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 website 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 spending accounts, request enrollment within 30 calendar days of the date of hire or of becoming eligible. The countdown begins on the day of the event. Once you have submitted a valid election during this enrollment window and that election takes effect, it is binding and may not be changed. When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the documentation, do not miss the enrollment deadline. You have an additional 30 days from the election request to submit the eligibility documentation. Note: Health care coverage will not be effective until approved documentation is received. See your agency Benefits Administrator.

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 FSAs effective July 1. When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the documentation, do not miss the enrollment deadline. You have an additional 30 days from the end of the Open Enrollment period to submit the eligibility documentation. Note: Health care coverage will not be effective until approved documentation is received. See your agency Benefits Administrator.

Qualifying Mid-Year Events (Life Events)

Certain qualifying mid-year events (life events) permit specific election changes outside the Open Enrollment period, including changes to your plan and membership. Examples of these 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 calendar days of the event and be on account of and consistent with the event. The countdown begins on the day of the event. Once you have submitted a valid election during this enrollment window and that election takes effect, it is binding and may not be changed. You will be asked to provide supporting documentation for the qualifying mid-year event (life event). *A complete list of qualifying mid-year events (life events) may be found on the DHRM website and on the attached enrollment form.* When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. If you do not have the documentation, do not miss the enrollment deadline. You have an additional 30 days from the election request to submit all the supporting documentation. Note: Health care coverage will not be effective until approved documentation is received. See your agency Benefits Administrator.

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 stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days of the day 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 of the marriage, birth, adoption or placement for adoption.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created two new Special Enrollment rights for certain eligible employees and dependents who lose coverage or become eligible for premium assistance under a Medicaid or state children's health insurance program. Employees must request coverage changes within 60 days of the eligibility determination.

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 unless you enroll in the TRICARE supplement. More information about Extended Coverage (COBRA) is available on the DHRM website 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.
- No person can be enrolled in more than one state health benefits plan under any circumstances. If it is determined that a person is covered in error, the plan has the right to take corrective action.

Flexible Spending Accounts allow you to set aside part of your salary each year 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 website or contact your agency Benefits Administrator.

- A flexible spending 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 spending account. They may not seek reimbursement through any other source.
- Enrollees must collect and maintain sufficient documentation to validate reimbursement from a flexible spending 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.**	• Photocopy of certified or registered 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.	• 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. **Note: Stepchildren are only eligible, while their natural parent remains eligible.**	• 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: • 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.	• Photocopy of the Final Court Order granting permanent custody with presiding judge's signature.

2025-2026 OPEN ENROLLMENT ELECTIONS ARE ACCEPTED MAY 16 - MAY 30, 2025.
RETURN TO VCU HUMAN RESOURCES. SEE RETURN INSTRUCTIONS AT THE BOTTOM OF PAGE 2 OF THIS FORM.

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. Employee 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.

☐ **Open Enrollment**

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

☐ **Qualifying Mid-Year Event (Life 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)
- ☐ Birth or Adoption (birth certificate/hospital announcement or adoption agreement)
- ☐ Judgment, Decree, or Order to Add Child (court order)
- ☐ Lost eligibility Under Governmental Plan (government documentation)
- ☐ Lost eligibility Under Medicare or Medicaid (government documentation)
- ☐ Spouse or Child Lost Eligibility Under Their Employers Plan (employer documentation)

Events consistent with removing family members from coverage:

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

Other events:

- ☐ Employment Change ☐ Full-time to Part-time ☐ Part-time to Full-time
- ☐ Unpaid Leave Began
- ☐ Unpaid Leave Ended
- ☐ Dependent Care Cost or Coverage Change (documentation from dependent care provider)
- ☐ HIPAA Special Enrollment Due to Loss of Other Coverage (HIPAA certificate)
- ☐ Move Affecting Eligibility for Health Care Plan (agency validates move)
- ☐ Other Employers Open Enrollment or Plan Change (employer documentation)
- ☐ 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)**

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

To enroll in or change an FSA, enter the annual amount you wish deducted. For assistance in determining your annual election amount, 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.** ***Attention:*** FSA plan year from July 1, 2025 - June 30, 2026.

HEALTH FLEXIBLE SPENDING ACCOUNT

For eligible medical expenses incurred by you, your spouse and eligible dependents. (Maximum allowable contribution is up to $3,300.)

Annual amount = _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

For eligible dependent care expenses incurred by you, your spouse and eligible dependents. (Maximum allowable contribution is up to $5,000 depending on your tax filing status.)

Annual amount = _____

TEAR OFF AT PERFORATION

Section 4: Health Care Coverage Election

☐ I do not wish to participate in health care coverage ***Warning:*** ***Checking this option will cancel any existing coverage!***

☐ 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 CarelonRx 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 Sentara Health Plans

☐ Sentara Health Plans HMO (formerly Optima) – available primarily in Hampton Roads zip codes (OH)

B. Family Members – Check the box that applies ***Attention: List ALL family members you wish to have coverage for!***

☐ 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 _____

Sign Here _____ Date _____

Section 6: Agency Verification and Approval

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

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

Employee ID or Social Security Number _____

Return to VCU Human Resources by ONE method: (1) Attach to HR request at https://go.vcu.edu/hrsupport; (2) email to openenroll@vcu.edu; (3) Upload to https://filelocker.vcu.edu and share with email openenroll@vcu.edu; OR (4) Mail to VCU HR, Box 842511, Richmond, VA 23284-2511.

TEAR OFF AT PERFORATION

2025-26 Language Assistance Statement
State Health Benefits Program

The Commonwealth of Virginia's State and Local Health Benefits Programs (the "Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Nondiscrimination Notice lists the services available and how to file a complaint if you feel that the Health Plan has failed to provide these services or discriminated in another way.

ATTENTION: If you need help in the language you speak, language assistance services are available to you free of charge. Send your request for language assistance to appeals@dhrm.virginia.gov or fax to 804-786-0356.

Spanish:
ATENCIÓN: Si necesita ayuda en el idioma que habla, servicios de asistencia lingüística están a su disposición de forma gratuita. Envíe su solicitud de asistencia lenguaje para appeals@dhrm.virginia.gov~~V o por fax al 804-786-0356.

Korean:
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Vietnamese:
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French:

ATTENTION: Si vous avez besoin d'aide dans la langue que vous parlez, les services d'assistance linguistique sont à votre disposition gratuitement. Envoyez votre demande d'assistance linguistique pour appeals@dhrm.virginia.gov~~V ou par télécopieur au 804-786-0356.

Russian:

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German:

ACHTUNG: Wenn Sie in der Sprache sprechen Sie Hilfe benötigen, die Sprache Hilfeleistungen zur Verfügung stehen Ihnen kostenlos zur Verfügung. Senden Sie Ihre Anfrage für sprachliche Unterstützung zu appeals@dhrm.virginia.gov~~V oder Fax an 804-786-0356.

Bengali:

Ā Ɇɳ äïČŪý ääĒĂ ĆđČđ ääĒĂ ïÿđ ąĊĘþ čđĎđĈΘ ƵĘĠđöĂ ĎĠ, þđĎĘĊ ĆđČđ čĎđĠþđ ĺčąđ ĒĂðĉôđ ääĂđĉ öĂΘ çăĊ⊄ appeals@dhrm.virginia.gov~~V ãÿąđ ĄΘđŮ ĆđČđ čĎđĠþđ ---- ïĉđĉ öĂΘ ääĂđĉ ãĂĚĘĉđā ăđúđĂ

Bassa:

Dè q_E nìà kE dyéq_e gbo: :) ju m ['BasJ,J'-wùq_ù-po-nyJ'] ju ni, nii, a wuq_u kà kò q_ò po-poJ'6Ei, n m ke gbo kpaa. Da 804-786-0356.

Igo (Igbo):

Ntj: O bµrµ na j ch9r9 enyemaka na asµsµ j na-asµ, asµsµ aka 9rµ dj ka j n'efu. Send gj arjrj9 maka asµsµ aka appeals@dhrm.virginia.gov~~V ma 9 bµ faksj ka 804-786-0356.

Yoruba:

Akiyesi: Ti o ba nilo iranl9w9 ninu ede ti o s9r9, ede iranlowo i y ni o wa wa si o free ti idiyele. Fi ìbéèrè ry fun ede iranlowo to appeals@dhrm.virginia.gov tabi Faksi to 804-786-0356.

Filipino (Tagalog):

Pansin: Kung kailangan mo ng tulong sa wikang nagsasalita ka, serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad. Ipadala ang iyong kahilingan para sa tulong sa wika upang appeals@dhrm.virginia.gov~~V o fax sa 804-786-0356.