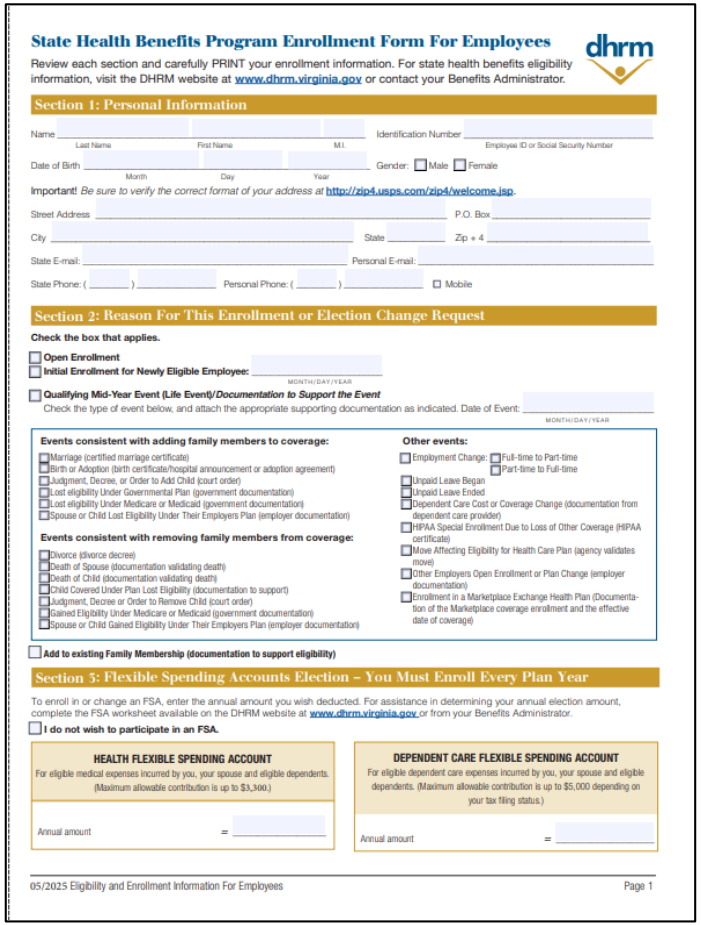
Completing the Open Enrollment Election Form

Open Enrollment for
Health Coverage and
Flexible Spending

May 16 – May 30, 2025



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.

dhrm

Section 1: Personal Information

Name _____ (Last Name / First Name / M.I.) Identification Number _____ (Employee ID or Social Security Number)

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

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.**

HEALTH FLEXIBLE SPENDING ACCOUNT	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT
For eligible medical expenses incurred by you, your spouse and eligible dependents. (Maximum allowable contribution is up to $3,300.)	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 = _____	Annual amount = _____

05/2025 Eligibility and Enrollment Information For Employees Page 1

Last Updated: 05/08/2025

Use Cardinal to make your open enrollment elections online whenever possible.
Cardinal is the fastest and most secure way to make open enrollment elections!

The enrollment form is a request for VCU HR to enter your data into Cardinal for you, but it is the same data and we enter it in the same system.

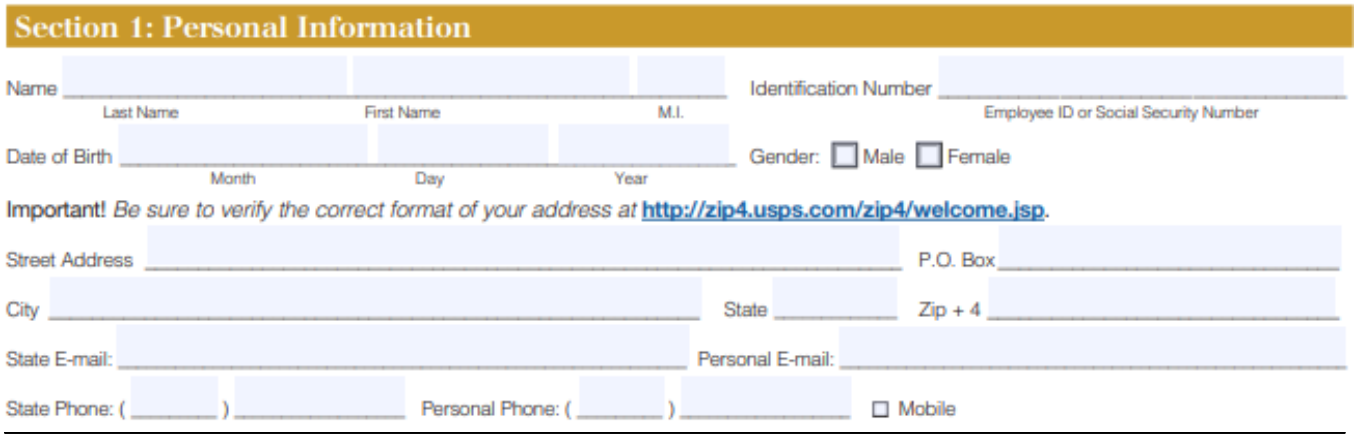
Do You Need To Take Action During Open Enrollment? Yes or No

I want to…	Do I still need to make an Open Enrollment election?
Participate in flexible spending accounts (FSA) for the July 2025 – June 2026 plan year	YES, even if you had a previous FSA
Change my health plan selection	YES
Change who is covered on my health plan	YES
Keep the same health plan with the same people covered, and not participate in the flexible spending accounts (FSA)	NO

No open enrollment election is required to keep your same health plan selection with the same covered family members.

Section I: Personal Information

- Enter your personal information as indicated
- For “Identification Number” use either your health plan member ID, Cardinal ID, or your Social Security number. Do not use your VCU V-ID number.
- For “State E-mail” and “State Phone” use your VCU contact information



Section 1: Personal Information

Name _____ (Last Name) _____ (First Name) _____ (M.I.) Identification Number _____ (Employee ID or Social Security Number)

Date of Birth _____ (Month) _____ (Day) _____ (Year) Gender: ☐ Male ☐ Female

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 _____

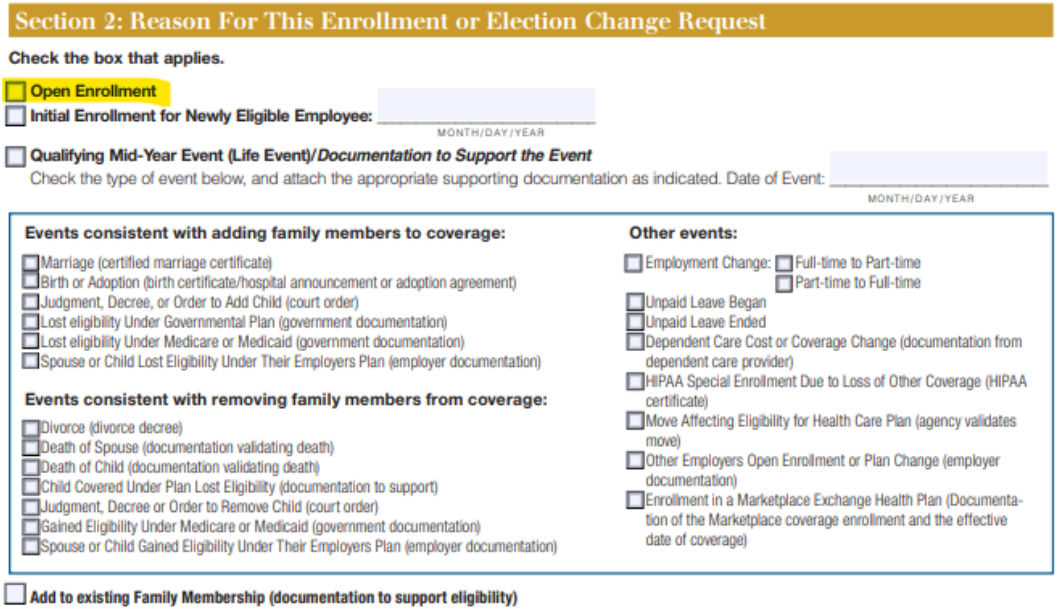
State E-mail: _____ Personal E-mail: _____

State Phone: (_____) _____ Personal Phone: (_____) _____ ☐ Mobile

Last Updated: 05/08/2025

Section 2: Reason for This Election

- Check “Open Enrollment” and make no other selections



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

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- ☐ 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:

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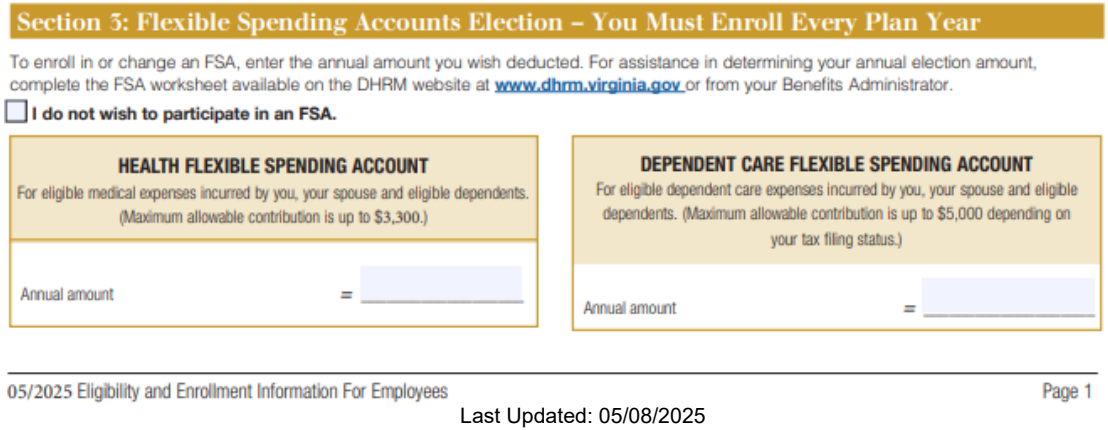
- ☐ Unpaid Leave Ended
- ☐ Dependent Care Cost or Coverage Change (documentation from dependent care provider)
- ☐ HIPAA Special Enrollment Due to Loss of Other Coverage (HIPAA certificate)
- ☐ Move Affecting Eligibility for Health Care Plan (agency validates move)
- ☐ Other Employers Open Enrollment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

- If you do not wish to participate in flexible spending, check “I do not wish to participate in an FSA,” **or**
- To elect participation, enter an **annual** contribution amount for the applicable FSA type(s). **Do not enter a per-pay-period amount.**



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.**

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 = _____

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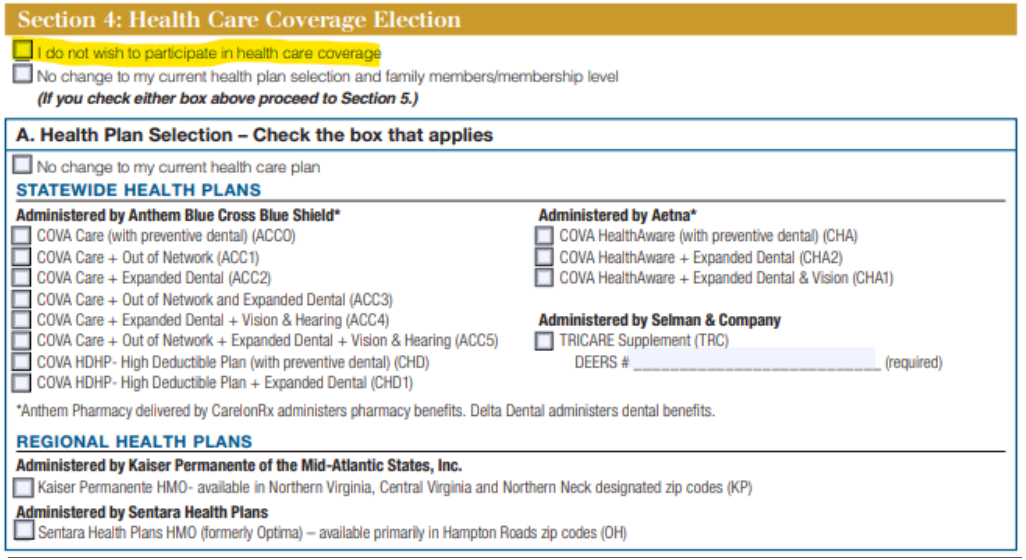
Section 4: Health Care Coverage

- If you wish to waive health coverage effective July 1, 2025, check the first box. This will cancel any current health coverage.



Section 4: Health Care Coverage Election

☐ I do not wish to participate in health care 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) (ACC0)
☐ 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.

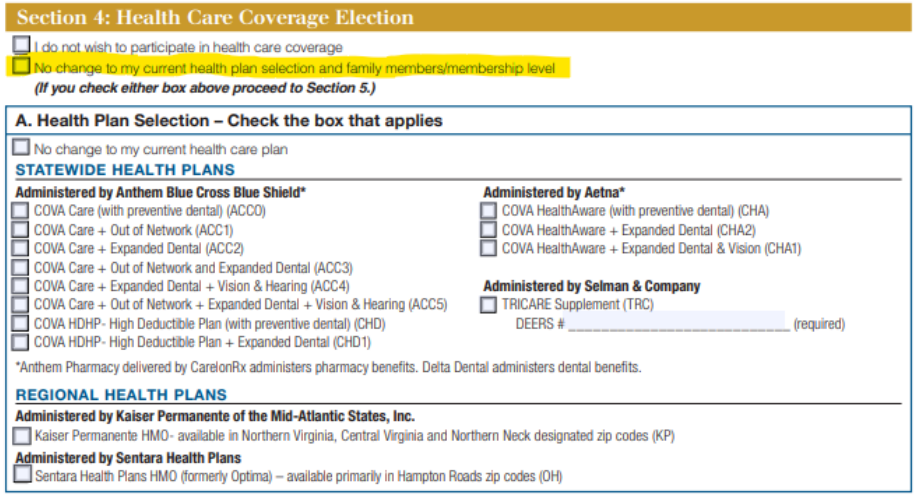
☐ Kaiser Permanente HMO- available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP)

Administered by Sentara Health Plans

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

Section 4: Health Care Coverage (continued)

- If you wish to retain your current health plan selection **and** covered family members for the plan year that begins July 1, 2025, check the second box.



Section 4: Health Care Coverage Election

☐ I do not wish to participate in health care 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)

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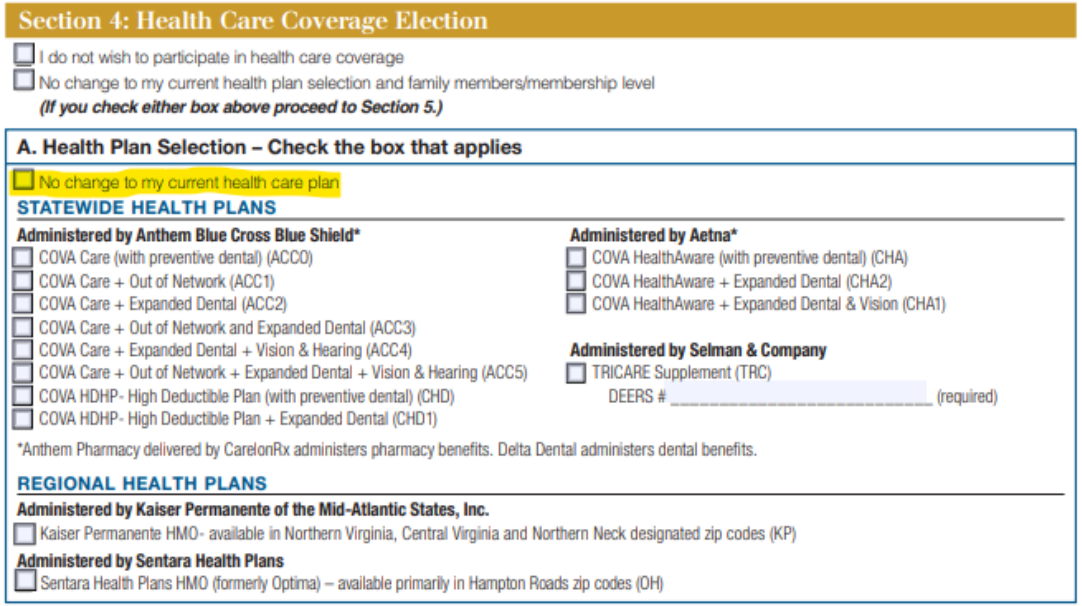
Administered by Sentara Health Plans

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

Section 4: Health Care Coverage (continued)

- If you wish to retain your current health plan selection but will be adding or removing family members effective July 1, 2025, check the box highlighted below.



Section 4: Health Care Coverage Election

☐ I do not wish to participate in health care 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

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☐ COVA Care (with preventive dental) (ACC0)
☐ COVA Care + Out of Network (ACC1)
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Administered by Selman & Company
☐ TRICARE Supplement (TRC)
DEERS # _____ (required)

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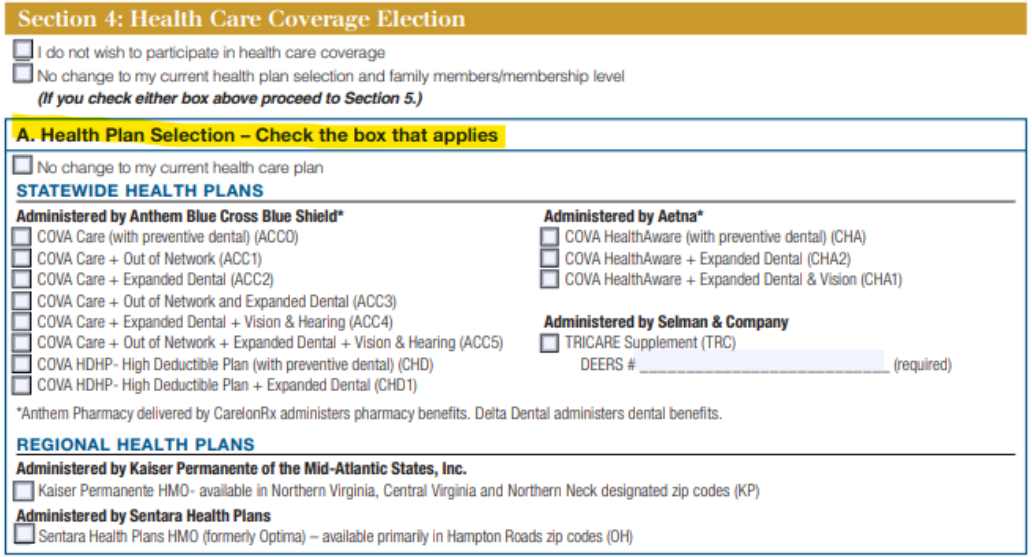
Section 4: Health Care Coverage (continued)

- If you wish to make a **new** health plan selection for the plan year that begins July 1, 2025, check your plan selection.



Section 4: Health Care Coverage Election

☐ I do not wish to participate in health care 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

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Section 4: Health Care Coverage (continued)

- If you changed your health plan above but want to cover the same family members as last year on your new plan effective July 1, 2025, check the first box ("No change to my existing covered family members").
- To cover **no family members** effective July 1, 2025, check the second box. All family members currently covered will be removed from your health plan effective July 1, 2025.
- To **add family members or remove some (but not all) family members** effective July 1, 2025, check the third box and make a list of **the family members you wish to cover as of July 1, 2025** (including any members you are already covering now that you will keep on your coverage). **Any family member that you do not list but who is currently covered will be removed from your health plan effective July 1, 2025.**

B. Family Members – Check the box that applies

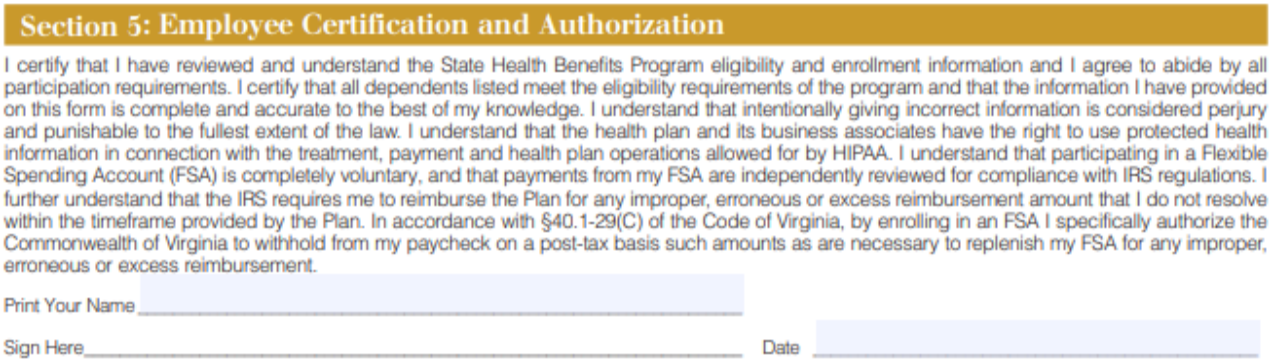
- ☐ No change to my existing covered family members
- ☐ I do not wish to cover any family members
- ☐ I wish to cover the eligible family members listed below. ***(Note: you will be required to submit documentation when adding family members to your coverage.)***

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

- Carefully review the certification and authorization, then print your name, sign, and date where indicated.



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

- This section is completed by VCU Human Resources. Please leave this section blank.

Last Updated: 05/08/2025

Tips and Reminders

- If you are removing a family member from coverage, **they should not be listed anywhere on your form**. Your updated list of covered family members will override any list currently on file.

- If you are listing any family member who is not currently covered, you must supply the required eligibility documents for that family member along with your election form. See the list of required documents at www.hr.vcu.edu/open-enrollment. **Your family member cannot be covered until the required eligibility documents are received.**

Tips and Reminders

- **Do not submit an open enrollment election unless you are:**
  - Making a change to your health plan selection, or
  - Making a change to your covered family members, or
  - Enrolling flexible spending

- **Do not make your open enrollment elections by more than one method.** Use **either** the online system (Cardinal) **or** an enrollment form. **Do not use both methods for the same elections.**

- If you wish to keep the same health plan selection and covered family members, and do not wish to enroll in flexible spending, you **do not** need to submit an open enrollment election.

Election Form Due Date

If you use an Election Form for open enrollment instead of using Cardinal online:

- Election forms returned electronically (HR Support Request, DocuSign, VCU File Locker) must be **received** by VCU Human Resources no later than May 30, 2025.
- Election forms returned by postal mail must be postmarked by May 30, 2025.

HR Support Request	VCU File Locker	Mail
http://go.vcu.edu/ramscentral **DocuSign** https://hr.vcu.edu/benefits/open-enrollment/	**https://filelocker.vcu.edu** Share with user ID "OPENENROLL" or share with email address openenroll@vcu.edu	VCU Human Resources Box 842511 600 West Franklin Street Richmond, VA 23284-2511 Campus Mail is not postmarked and is not recommended for open enrollment elections.

Keep a copy of your form, and your mailing or transmission receipt, for your records

If you choose to hand deliver your form to VCU Human Resources, it must be received by 5:00 pm on May 30, 2025.

Last Updated: 05/08/2025

If you are adding family members to health coverage…

- Eligibility documents are **required** for each family member you add or re-add to health coverage during open enrollment. Documents are not required for currently covered family members that are staying on your plan without interruption.
- See the list of required documents at https://hr.vcu.edu/benefits/open-enrollment/.
- Submit documents along with your election form.
- If you don't have the documents by May 30, submit your election form by the open enrollment deadline, and your election to cover the affected family member(s) will be held for up to an additional 60 days while you obtain the documents.
- If the documents are not received by 30 days after the open enrollment deadline, your election to cover the family member(s) will be declined.

We're Here to Help!

VCU Human Resources

Benefits Administration

http://go.vcu.edu/ramscentral

openenroll@vcu.edu

Our ability to respond to telephone inquiries is limited during open enrollment. Please use the HR support ticketing system or email for the best service.

Last Updated: 05/08/2025