Commonwealth of Virginia

State Health Benefits Program Enrollment Form For Retirees, Survivors and LTD Participants

dhrm
Virginia Department of HUMAN RESOURCE MANAGEMENT

Instructions for completing this form. Open Enrollment elections require completing Parts A, B, D and E.

Part A. Enrollee Information – (Retiree, Survivor or LTD Participant Information Only – Not Family Member Information)

☐ Check here if this is an address change. Identification Number or Social Security Number _____

Print Name _____/_____/_____
(First) (M.I.) (Last)

Address _____ City _____ State _____ Zip + 4 _____

Day Time Phone (_____) _____ Birth Date_____/_____/_____ Sex: ◯ Male ◯ Female
Month Day Year

E-mail Address _____

REASON FORM IS BEING SUBMITTED *(Check each appropriate category)*

☐ **Initial Enrollment.** *Check one:* ◯ Retirement ◯ VSDP LTD initial enrollment/waiver or other LTD initial enrollment
◯ Survivor Enrollment ◯ Re-enrolling from family member status in active/other retiree coverage or from other active eligibility
(Date losing other coverage _____)

☐ **Now Eligible For Medicare.** ◯ Retiree/Survivor ◯ Spouse ◯ Child ◯ VSDP or other LTD Participant

☐ **Open Enrollment (available to Non-Medicare Participants Only) To Change Plans And/Or Membership.**
◯ Enrollee/Enrollee and Family members ◯ Family member with Separate Coverage

☐ **Remove Family member(s) From My Coverage.** (Change will be effective the first day of the month after this form is received.)

Name of Family member(s) _____ Social Security or ID Number _____
If you are removing a family member due to a Life Event (qualified mid-year event), please indicate the event below.

☐ **Medicare Eligible Member Making Allowable Plan Change.** (Effective date will be the first of the month after this form is received.)
◯ Retiree/Survivor ◯ Spouse ◯ Child ◯ VSDP or other LTD Participant

☐ **Cancel/Waive Coverage (go to Part F.).**

☐ **Life Event (Qualifying Mid-Year Event).** Check the type of event below, and attach the appropriate supporting information as indicated *(see **bold italics**)*. Please complete participant information in Part B. Submit this change within 60 days of the event. In most cases, the change will be effective the first day of the month following receipt of this form. HIPAA Special Enrollments* allow the addition of all eligible family members.

(Event if applicable/*Attach This Information)* **Date of Event** _____

Events That Are Consistent With Increasing Membership**

- ☐ Marriage/***Marriage Certificate****
- ☐ Birth or Adoption/***Birth Certificate or Adoption Agreement****
- ☐ Eligible family member loses eligibility for Medicare, Medicaid or other government plan/***Government Documentation***
- ☐ Spouse or eligible child loses employer eligibility/***Employer Documentation***
- ☐ Judgment, decree or order requiring coverage of an eligible child/***Court Order***
- ☐ Permanent custody granted/***Court Order***
- ☐ Spouse's, eligible child's or LTD participant's open enrollment or significant change under another employer's plan resulting in termination of coverage/***Employer Documentation to Support Change***
- ☐ Other HIPAA Special Enrollment *
  - ☐ LTD Participant or family member loses coverage for which they declined enrollment in this plan
  - ☐ Family member loses coverage in Medicaid or the State Children's Health Insurance Program (CHIP)
  - ☐ Family member becomes eligible for a Medicaid or CHIP premium assistance subsidy

Events That Are Consistent With Decreasing Membership

Retiree group participants can reduce membership prospectively at any time, with or without the events described below. Some of these events may allow enrollment in Extended Coverage.

- ☐ Divorce/***Divorce Decree***
- ☐ Death of spouse or child/***Death Certificate***
- ☐ Child loses eligibility/***Documentation to Support***
- ☐ Judgment, decree or order to remove child/***Court Order***
- ☐ Covered family member gains eligibility for Medicare or Medicaid/***Government Documentation***
- ☐ Spouse or covered child gains employer eligibility/***Employer Documentation***
- ☐ Spouse or covered child's open enrollment or significant change under another employer's plan resulting in eligibility for coverage/***Employer Documentation to Support Change***
- ☐ Enrollment in Marketplace Exchange Health Plan

Allows Plan Change

- ☐ Move affecting eligibility for Health Care Plan/*Benefits Administrator Validates Move*

** *When adding eligible family members to coverage, supporting documentation is required that provides proof of eligibility. Your Benefits Administrator can provide additional information.*

TYPE OF MEMBERSHIP

Please select the membership type which describes the membership level for which you are enrolling:

☐ **Single Coverage** ☐ **Two people** ☐ **Family** – Enrollee with Two or More Family Members

Part B. Enrollment

List all Medicare and Non-Medicare participants. Include yourself and everyone you are enrolling in a health plan (including all participants, not just additions or changes). Attach a copy of Medicare cards for all members who are Medicare-eligible.

Relationship Codes: E = Retiree, LTD or Survivor SF = Spouse female SM = Spouse male S = Son D = Daughter
SS = Stepson SD = Stepdaughter OF = Other female child OM = Other male child

NAME	Birthday MM/DD/YYYY	Social Security Number	Relationship Code	Medicare Information (if applicable)		
				Medicare Claim No.	Part A Effective Date	Part B Effective Date

HEALTH BENEFITS PLAN SELECTION

Enrollees must select a plan based on their and their family members' Medicare eligibility. Participants who are eligible for Medicare, regardless of age, must select a plan in Part C, and those who are not eligible for Medicare must select a plan in Part D. Enrollment in a Medicare-coordinating (Medicare is primary) plan must take place immediately upon any participant's eligibility for Medicare.

If you are making a plan change, you will only receive new ID cards that require updated information. 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.

Part C. Plans For Retiree Group Participants Eligible For Medicare

If you are eligible for Medicare and have not enrolled in both Hospital Part A and Medical Part B of Medicare, contact your local Social Security Administration office. If you enroll in a plan that includes prescription drug coverage, you will be enrolled in Medicare Part D (pending approval by Medicare.) If you enroll in a Medicare Part D plan outside of the state program, you will be moved to Medical-Only coverage and may not return to the state program's Medicare Part D plan.

Please select a plan below and indicate whether the coverage is for you or a family member.

PLAN	COVERAGE FOR (check all that apply)			
○ **Advantage 65 (A65)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
○ **Advantage 65 with Dental/Vision (65DV)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
○ **Advantage 65 – Medical Only* (65MO)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child
○ **Advantage 65 – Medical Only* with Dental/Vision (MODV)**	☐ Retiree/Survivor	☐ VSDP or other LTD	☐ Spouse	☐ Child

**** Does not include coverage for outpatient prescription drugs.***

The plans below may be selected only by members currently enrolled in an Option II/Medicare Supplemental plan.

PLAN	COVERAGE FOR (check all that apply)		
○ **Option II (B2)**	☐ Retiree/Survivor	☐ Spouse	☐ Child
○ **Option II with Dental/Vision (B2DV)**	☐ Retiree/Survivor	☐ Spouse	☐ Child

Dental/Vision coverage may be added to either Advantage 65, Advantage 65 – Medical Only, or Option II at any time, and it may be cancelled at any time. However, once the Dental/Vision option has been elected and cancelled one time in any Medicare-coordinating plan, it may not be elected again. Participants in Option II may enroll in Advantage 65 (including Advantage 65 – Medical Only) at any time. However, once enrolled in any Advantage 65 plan, Option II may not be elected again. Except for initial enrollment in a Medicare-coordinating plan, these elections/changes are effective the first of the month following receipt of your request.

Part D. Plans For Retiree Group Participants Not Eligible For Medicare

All non-Medicare family members must enroll in the same plan.

STATEWIDE HEALTH PLANS	
❑ COVA Care (with preventive dental) (ACC0)	❑ COVA HealthAware (with preventive dental) (CHA)
❑ COVA Care + Out of Network (ACC1)	❑ COVA HealthAware + Expanded Dental (CHA2)
❑ COVA Care + Expanded Dental (ACC2)	❑ COVA HealthAware + Expanded Dental & Vision (CHA1)
❑ COVA Care + Out of Network and Expanded Dental (ACC3)	❑ COVA HDHP - High Deductible Plan (with preventive dental) (CHD)
❑ COVA Care + Expanded Dental + Vision & Hearing (ACC4)	❑ COVA HDHP - High Deductible Plan + Expanded Dental (CHD1)
❑ COVA Care + Out of Network + Expanded Dental + Vision & Hearing (ACC5)	❑ TRICARE Supplement (TRC) DEERS # _____ (required)
REGIONAL HEALTH PLAN	
❑ Kaiser Permanente HMO - available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP)	
❑ Sentara Health Plans HMO (Formerly Optima) - available primarily in Hampton Roads zip codes (OH)	

Part E. Authorization, Enrollee Statement, And Certification

ENROLLEE STATEMENT: I want to enroll or make an allowable change in the Retiree Health Benefits Program. The cost of coverage will be deducted from my Virginia Retirement System (VRS) retirement benefit. If I am not receiving a VRS monthly benefit, or if my VRS monthly benefit will not accommodate my health insurance premium, I will be billed directly. To cancel coverage, I must send my request in writing to the appropriate recipient noted on page 5. Cancellation of coverage will be effective the end of the month in which my written request is received. I understand that notice of cancellation does not relieve me from payment for monthly coverage that has already begun. I understand that if I cancel my state retiree coverage, I will not have another opportunity to enroll in the Retiree Health Benefits Program, and that if I do not enroll into prescription drug or cancellation of prescription drug and/or Dental/Vision benefits will preclude any future enrollment for those benefits. I understand that my health premiums are subject to change. I am aware that the Commonwealth of Virginia reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that failure to pay premiums by the date designated on my monthly bill, if applicable, will result in cancellation of coverage and will permanently revoke my eligibility for the program. Further, I understand that claims may not be processed for services during months for which premium payment in full has not been received. I understand that enrolling or maintaining coverage for ineligible family members may result in removal from the State Retiree Health Benefits Program for up to three years.

CERTIFICATION/AUTHORIZATION: I certify that I understand the State Retiree Health Benefits Program eligibility criteria and agree to abide by all participation requirements. I certify that all family members listed meet the eligibility requirement 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.

Enrollee's Signature[1] _____ **Date** _____

Print Name _____

[1]*Family members are not authorized to sign this form. It must be signed by the Retiree, Survivor or LTD Participant.*

Part F. To Waive Or Cancel State Coverage

RETIREES AND/OR SURVIVORS

Name _____ Effective Date or Terminate Date _____
(First) (M.I.) (Last) (MM/DD/YYYY)

Employee ID or Social Security Number _____ Telephone Number _____

WAIVE COVERAGE

☐ **I am a retiree and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent life event (qualifying mid-year event),I will be eligible to apply for retiree coverage only within 31 days of that event.

Spouse's Name _____ Spouse's Employee ID or Social Security Number _____

CANCEL/DECLINE COVERAGE

◯ **I am a new retiree* and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll except as allowed in **WAIVE COVERAGE** section.
**Includes retirees ending their 12-month severance/transitional benefit period.*

◯ **I am a current retiree/survivor and wish to cancel my coverage in the State Health Benefits Program for retirees.** I understand that neither I nor my family members will be permitted to re-enroll in the program at any time. This serves as my written notification and authorization to cancel my coverage and that of my covered family members. This will be effective the first of the month after notice is received.

◯ **I am a retiree or survivor who has become eligible for coverage in an active state plan and I wish to cancel my retiree coverage.** I understand that I may re-enroll in the retiree program within 31 days of the loss of active coverage and that I must have maintained continuous coverage in the State program to do so unless I become newly eligible for retiree coverage.

If you are entitled to a Health Insurance Credit, waiving or canceling State coverage in no way affects your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

NEW VSDP/LTD PARTICIPANTS

Name _____ Effective Date _____
(First) (M.I.) (Last)

Employee ID or Social Security Number _____ Telephone Number _____

WAIVE COVERAGE AT START OF LTD:

◯ **I am a new VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll unless I experience a life event (qualifying mid-year event) or Open Enrollment. (Open Enrollment is available to non-Medicare participants only).

◯ **I am a VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent life event (qualifying mid-year event), I will be eligible to apply for retiree group coverage only within 31 days of that event.

Spouse's Name _____

Spouse's Employee ID or Social Security Number _____

VSDP/LTD Waive or Cancel for existing participants:

◯ **VSDP/LTD Waiver of Health Coverage due to Open Enrollment, or a Life Event (Qualifying Mid-Year Event)** [indicate event on page 1]
◯ **VSDP/LTD Cancellation of Coverage without Open Enrollment or a Life Event (Qualifying Mid-Year Event)**

If you are entitled to a Health Insurance Credit, waiving or canceling coverage does not affect your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

If You Are Using This Form To. . .	Complete Part(s) . . .
• Enroll in plan that coordinates with Medicare	A, B, C, E
• Enroll in Non-Medicare State plan	A, B, D, E
• Enroll in *combination* of plans above	A, B, C, D, E
• Change plans and/or type of membership	A, B, C and/or D, E
• Make an Open Enrollment change (non-Medicare participant only)	A, B, D, E
• Waive or cancel participation in the State Health Benefits Program	F
• Waive existing coverage in VSDP/LTD due to open enrollment or a life event (qualifying mid-year event), or cancel VSDP/LTD coverage	A, E
• Enroll in Extended Coverage/COBRA	Use your Election Form, part of your Election Notice.
• Change your address	A, E

If You Are A...	Send Completed Form To . . .
• New Retiree or New Survivor of Active State Employee • New VSDP or other LTD Participant	The Employing Agency's Benefits Administrator
• Current VRS Retiree or Survivor* • Current VSDP/LTD Participant*	Virginia Retirement System P.O. Box 2500 • Richmond, VA 23218-2500
• All Other Retirees, Survivors, or LTD Participants (Optional Retirement Plan, Local Retiree, etc.)	Your former Agency's Benefits Administrator

** Including family members who have separate plans from the Enrollee*

Agency Approval/Agency Use Only

The Benefits Administrator is responsible for forwarding a copy of the completed enrollment form to the retiree group Benefits Administrator (e.g., VRS).

Agency Name _____ Agency Number _____ Coverage Effective Date _____

I have reviewed this form, and verified that the retiree, survivor or LTD participant is eligible for the plan or waiver selected. I certify that the information on this form is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date _____

Print Name and Title _____ Phone Number _____

This participant is enrolling as:

☐ Virginia Retirement System Retiree/Survivor ☐ Local Retiree/Survivor

☐ ORP Retiree/Survivor (name of ORP Vendor) _____

☐ VSDP/LTD Participant ☐ Other LTD Participant ☐ Non-Annuitant Survivor

The participant has been told that the first premium would be in the amount of $_____

If retiring, indicate type of retirement: ☐ Service Retirement ☐ Disability Retirement Retirement Date: _____

VRS Use Only (For Existing Retiree Group Members)

Date Form Received _____ Effective Date of Change (subject to DHRM approval) _____

For Disability Retirees:

Date of Approval Letter _____ Date of Retirement _____

2025-26 Language Assistance Statement

State Health Benefits Program

Virginia Department of HUMAN RESOURCE MANAGEMENT

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:
주의 : 당신이 말하는 언어로 도움이 필요한 경우, 언어 지원 서비스를 무료로 당신에게 사용할 수 있습니다. 804-786-0356에 언어 appeals@dhrm.virginia.gov~~V하는 지원이나 팩스에 대한 요청을 보냅니다.

Vietnamese:
Chú ý: Nếu bạn cần giúp đỡ trong ngôn ngữ bạn nói, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gửi yêu cầu để được hỗ trợ ngôn ngữ đến appeals@dhrm.virginia.gov~~V hoặc fax 804-786-0356.

Chinese:
注意：如果你需要在你講的語言幫助，語言協助服務提供給您免費。發送您的語言協助 appeals@dhrm.virginia.gov~~V或傳真至804-786-0356請求。

Arabic:
تنبيه: إذا كنت بحاجة إلى مساعدة باللغة التي تتحدثها، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا.
أرسل طلبك للحصول على المساعدة اللغوية عبر البريد الإلكتروني إلى appeals@dhrm.virginia.gov أو عبر الفاكس إلى 804-786-0356.

Persian:
توجه: اگر شما نیاز به کمک در زبان شما صحبت می کنند، خدمات کمک زبان در دسترس شما هستند رایگان می باشد. ارسال درخواست خود را برای کمک به زبان appeals@dhrm.virginia.gov~~V.0356-786-804 یا فکس به

Amharic:
አዳምጥ: አንተ የሚናገሩት ቋንቋ እርዳታ የሚፈልጉ ከሆነ ,የ ቋንቋ እርዳታ አገ ልግሎቶች ከክፍያ ነፃ ለእርስዎ የሚ ኙ ና ቸው. 804-786-0356 ቋንቋ appeals@dhrm.virginia.gov~~V እርዳታ ወይም በ ፋክስ ጥያ ቄዎን ይላ ኩ.

Urdu:
توجہ فرمائیں: اگر آپ کو اپنی بولی جانے والی زبان میں مدد درکار ہے تو زبان میں مدد کی خدمات آپ کے لیے بالکل مفت دستیاب ہیں۔
زبان میں مدد کے لیے اپنی درخواستیں appeals@dhrm.virginia.gov پر بھیجیں یا 804-786-0356 پر فیکس کریں۔

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:
ВНИМАНИЕ: Если вам нужна помощь на языке вы говорите, переводческие услуги доступны бесплатно. Отправьте запрос о помощи языка к appeals@dhrm.virginia.gov~~HEAD=pobj~~V или по факсу 804-786-0356.

Hindi:
ध्यान दें: यदि आपको उस भाषा के लिए मदद की ज़रूरत है, जिस भाषा में आप बात करते हैं, तो आपके लिए भाषा सहायता सेवाएं निशुल्क में उपलब्ध हैं। भाषा की सहायता के लिए अपना अनुरोध appeals@dhrm.virginia.gov पर या फ़ैकस के लएि 804-786-0356 पर भेजें।

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:
দৃষ্টি আকর্ষণ: আপনি ভাষা আপনি কথা বলতে সাহায্য প্রয়োজন হয়, তাহলে ভাষা সহায়তা সেবা নিখরচা আপনার জন্য উপলব্ধ. appeals@dhrm.virginia.gov~~V অথবা ফ্যাক্স ভাষা সহায়তা 804-786-0356 করার জন্য আপনার অনুরোধ পাঠান.

Bassa:
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀bɛ́ìn m̀ ké gbo kpáa. Đá 804-786-0356.

Igo (Igbo):
Ntị: Ọ bụrụ na ị chọrọ enyemaka na asụsụ ị na-asụ, asụsụ aka ọrụ dị ka ị n'efu. Send gị arịrịọ maka asụsụ aka appeals@dhrm.virginia.gov~~V ma ọ bụ faksị ka 804-786-0356.

Yoruba:
Akiyesi: Ti o ba nilo iranlọwọ ninu ede ti o sọrọ, ede iranlowo iṣẹ ni o wa wa si o free ti idiyele. Fi ìbéèrè rẹ 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.