Anthem BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

Enrollment/Change Form - Henrico County General Government and Public Schools

A. SUBSCRIBER INFORMATION (To be completed by Employee) Complete Sections A through D

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS
(Choose One of the four plans)

○ Standard POS ○ Premier POS ○ HDHP HSA ○ Out-of-Area PPO

○ **Decline Coverage**. I elect to decline coverage with the Henrico County General Government and Public Schools. I will not be eligible to enroll until the next open enrollment period or a qualifying event.

PLEASE MAKE THE FOLLOWING CHANGES: **Please include supporting documentation for the change.**

ENROLL
- ○ Open Enrollment
- ○ New Hire (date of hire)_____
- ○ COBRA (date of eligibility)_____
- ○ Qualifying Event (description/date)_____

TERMINATE COVERAGE
- ○ Cancel Coverage

CHANGE
- ○ Add Dependent
- ○ Delete Dependent
- ○ Name Change (previous name) _____
- ○ Plan Change
- ○ Address Change

EMPLOYMENT STATUS
Please check one:
- ○ ACTIVE
- ○ RETIRED
- ○ TERMINATED

Please check one:
- ○ GENERAL GOVERNMENT
- ○ SCHOOLS

MARITAL STATUS
Please check one:
- ○ SINGLE
- ○ WIDOWED
- ○ MARRIED
- ○ DIVORCED

LAST NAME	FIRST NAME	MI	⊙ MALE ○ FEMALE	BIRTHDATE	SOCIAL SECURITY NUMBER

ADDRESS		
CITY	STATE	ZIP

HOME PHONE	WORK/DAY PHONE	EMAIL ADDRESS

B. DEPENDENT MEMBERS TO BE COVERED OR DELETED — ALL FIELDS REQUIRED

FAMILY MEMBERS TO BE COVERED OR DELETED	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER
○ E ○ D		○ M ○ F			
○ E ○ D		○ M ○ F			
○ E ○ D		○ M ○ F			
○ E ○ D		○ M ○ F			

C. OTHER INSURANCE - Do you or your covered dependents have other medical coverage? ○ Y ○ N If Yes, complete the following:

List all family members with medical coverage in addition to Anthem.

POLICY HOLDER	BIRTHDATE	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENTS COVERED		EFFECTIVE DATE	CONTRACT NO/GROUP NO.

D. CONDITIONS OF ENROLLMENT/SUBSCRIBER SIGNATURE

I hereby apply for membership or request a change in membership in Henrico County General Government and Public Schools Benefit Plan administered by Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. (Anthem). I understand that my enrollment and benefits are in accordance with those described in the applicable Health Plan Document. I authorize 1) all health providers and insurers to furnish Anthem, and 2) all health providers and Anthem to furnish all insurers and health providers records concerning me or any of my covered individuals for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Henrico County General Government and Public Schools as administered by Anthem.

Subscriber Signature _____ **Date** _____

E. EMPLOYER INFORMATION (To be completed by Employer)

Group No.	Effective Date:
Employer's Signature	Date:

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DELTA DENTAL

Group Enrollment Application

(New Enrollment/Changes to Enrollment)

Delta Dental of Virginia
4818 Starkey Road, Roanoke, VA 24018
(540) 989-8000 ·(800) 237-6060
Fax: (540) 776-8109

IMPORTANT: Enrollment Application with incomplete or missing information will be returned.

THIS SECTION TO BE COMPLETED BY GROUP ADMINISTRATOR

Account Name: Henrico County Government and Public Schools		Effective Date:
Account No: 00000600084	Sub-Account No:	Sub-Sub Account No:
Department:		Benefit Plan ID:
Employment Status (choose one): ☐ Active ☐ COBRA ☐ Line of Duty ☐ Retiree		Employee Type (choose one): ☐ Full-Time

Section A: ENROLLMENT/CHANGE (For qualifying event provide date and reason)

☐ New Hire ☐ Open Enrollment ☐ Reinstatement ☐ Cancel Coverage ☐ COBRA (Effective Date ____/____/____)
Qualifying Event: ☐ ADD dependent, spouse, or domestic partner ☐ DROP dependent, spouse, or domestic partner
☐ Name: Previous Name _____ ☐ Address ☐ Telephone ☐ Other _____
☐ Decline Coverage - I understand that I have been offered and have elected to decline coverage under my employer sponsored dental plan with Delta Dental at this time. I will not be eligible to enroll until the next open enrollment period or in the event of a qualifying event.
(Sign, date and complete first line of Section B.) **Signature** _____ Date _____

Date of Qualifying Event	Reason(s) for Qualifying Event
/ /	☐ Marriage ☐ Loss of other group coverage ☐ Divorce ☐ No longer a dependent ☐ Birth or adoption ☐ Death of spouse/dependent ☐ Other _____

Section B: EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security Number - -	Group Assigned ID (if applicable)

Mailing Address (#, Street, Apt)	City	State	ZIP

Home Telephone	Date of Birth	Gender	Marital Status	Date of Hire	Number of Hours Worked Per Week
( )	/ /	☐ Male ☐ Female	☐ Single ☐ Married	/ /	

Email Address ☐ I agree to receive communications regarding my group plan via the email address I have supplied on this application.

Section C: COVERAGE

Product (check one)	Plan	Coverage Type (check one)
☐ Delta Dental PPO℠ plus Premier ☐ Delta Dental PPO℠ - EPO Plan Design	☐ Low Option/Retirees ☐ High Plan Option/Retirees ☐ EPO Plan Design/Retirees ☐ Low Option/Active ☐ High Option/Active ☐ EPO Plan Design/Active	☐ Employee ☐ Employee + Child ☐ Employee + Spouse ☐ Employee + Family

Section D: LIST ALL MEMBERS TO BE ENROLLED/DROPPED BASED ON THE COVERAGE TYPE SELECTED

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F)	Date of Birth (MM/DD/YYYY)
☐ Add ☐ Drop						
☐ Add ☐ Drop						
☐ Add ☐ Drop						
☐ Add ☐ Drop						

Section E: AUTHORIZATION AND CERTIFICATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Virginia, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for underwriting purposes. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

I understand that my selection of coverage may be changed only during the open enrollment period of each year unless I experience a qualifying event listed under "Reasons for Qualifying Event" in Section A. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may have violated state law. I certify that the information supplied by me on this form is accurate to the best of my knowledge.

Signature: _____ Date: _____

Your privacy is important to Delta Dental of Virginia. We are committed to safeguarding your protected health information and are making every reasonable effort to ensure we maintain that information securely.

To learn more about how your dental information may be used and disclosed, and how you can get access to this information, please visit our website at deltadentalva.com/privacypractices.aspx. To request a printed copy of the privacy notice, contact us at Delta Dental of Virginia, attention: Privacy Unit, 4818 Starkey Road, Roanoke, VA 24018 or by calling 800-234-6060.

Delta Dental of Virginia Privacy Practices

Protecting the privacy and confidentiality of information about our customers is very important to Delta Dental of Virginia. Accordingly, we strive to comply with each of the following practices.

Notice of Insurance Information Practices:

1. Personal information may be collected from persons other than an individual(s) proposed for coverage.
2. This information, as well as other personal or privileged information collected later, may, in certain circumstances, be disclosed to third parties without authorization.
3. You may access and correct all personal information that is collected.
4. You will be furnished a more complete explanation of our information practices upon request.

Notice of Financial Information Collection and Disclosure Practices:

1. Financial information collected or received in connection with an insurance transaction may, in certain circumstances, be disclosed to non-affiliated third parties.
2. The individual to whom the financial information pertains may direct that it not be disclosed except as provided by Virginia Code Section 38.2-613.
3. This right may be exercised at any time and remains in effect until the individual revokes it.
4. To direct that your financial information not be disclosed except as provided by Virginia Code Section 38.2-613, you may send a signed letter to that effect to us at the following address:

Delta Dental of Virginia
Benefit Services
Attn: Privacy Coordinator
4818 Starkey Road
Roanoke, Virginia 24018

5. A non-affiliated third party to whom financial information is disclosed may disclose it to any other person if disclosure would be permitted by Virginia Code Section 38.2-613.
6. We will furnish you a more complete explanation of our financial information collection and disclosure practices upon request. To receive a copy of this explanation, please (a) contact us at the address in paragraph 4 of this notice or (b) call us at 1-800-237-6060.

2024 Plan Year: 1/1/2024 – 12/31/2024

County of Henrico General Government

Flexible Spending Account (FSA) Employee Enrollment Form

Please complete each line on the enrollment form even **if you are not enrolling in this benefit.**

Return the completed and signed form to your employer for processing.

PARTICIPANT INFORMATION – Please write legibly to ensure proper enrollment.

All fields are required for account setup. Information is confidential and is not used for marketing purposes.

Last Name, First Name	**SSN / Employee ID #**

Home Address (Street, City, State, Zip Code)	**Email Address**

Date of Birth (MM/DD/YYYY)	**Phone Number**	**Effective Date**

ANNUAL ELECTIONS

Section 125 Benefit	Yes/No	Annual Election	# of Paychecks	Paycheck Deduction
Health Care FSA Maximum of $3,050.00 per plan year	☐ Yes ☐ No	$_____	____24 ____Other	$_____
Day Care FSA Maximum of $5,000.00 per plan year (or $2,500 if you're married and filing taxes separately)	☐ Yes ☐ No	$_____	____24 ____Other	$_____

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

☐ **YES**, the above benefits have been explained to me and I elect to participate as indicated

☐ **NO**, the above benefits have been explained to me and I decline participation

Employee Signature **X**	**Date**

COMPLETED ENROLLMENT FORMS MUST BE RETURNED TO:

County of Henrico General Government
Department of Human Resources, Benefits Division
HR-Benefits@henrico.gov
804-501-7371 p. 804-501-4426 f.

Please see the reverse side for important information regarding the above benefits

ADDITIONAL INFORMATION

Health Care Flexible Spending Arrangement ("Health Care FSA")

- Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
- Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA and will be deducted pre-tax through the Premium Conversion Plan. Therefore, do not include the cost of premiums in your FSA annual election amount.

Day Care Flexible Spending Account ("Day Care FSA")

- Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
- Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If you or your spouse is a full-time student, please consult IRS Publication 503.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the $5,000 calendar year limit mandated by the IRS.

Use-It or Lose-It

- You must claim all elected funds by the end of the run-out period. After the run-out period is complete, unused Day Care FSA balances will be forfeited; this is referred to as the Use-it or Lose-it rule.
- Unused Health Care FSA balances up to $550 will be rolled over to the subsequent plan year. Any Health Care FSA funds more than $550 will be forfeited.

Claim Runout Period

- The claim runout period allows you to submit claims after the end of the plan year. Claims received after this period will be denied.

Deductions

- FSA deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form. If you enroll in the plan after Open Enrollment then please divide your annual election by the remaining deductions in the plan year.

Change in Status

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document for a list of qualifying events.
- In the event of a change in status the change in election must be necessitated by and consistent with the change in status and the change must be acceptable under IRS Regulations.

Eligibility

- Full-time and part-time employees working 20 hours per week are eligible to participate in the Plan
- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from the carrier, agents, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at any time at no cost. To withdraw consent, please contact the carrier directly.
- You have a right to receive a paper version of an electronically furnished document at no cost.
- To access documents, you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.

MetLife Short Term Disability Plan
Enrollment Form

Personal Information:

Name: _____

Social Security #: _____

Hire Date: _____

Coverage Effective Date: _____

Please check ONE box below and sign at the bottom:

☐ **Option 1: 14 Day Waiting Period for Benefits**

☐ **Option 2: 28 Day Waiting Period for Benefits**

☐ **Option 3: 42 Day Waiting Period for Benefits**

☐ **Option 4: I waive the options above.**

I authorize my employer to deduct premiums for the selected coverage from my paycheck on a post-tax basis.

If you are a Hybrid Plan Member with the Virginia Retirement System, *for your first year of employment*, Hybrid Plan members may enroll in the MetLife Short Term Disability/Income Protection. Enrollment provides income protection during the one-year eligibility period before filing a claim under the Hybrid Disability Program. VRS Hybrid Plan Members **cannot** make changes to your MetLife STIP enrollment after your 31-day window from your date of hire to make changes to your initial elections.

Signature _____ **Date** _____

2024 MetLife Short Term Disability Income Protection Rates

Choose from the 14-Day, 28-Day, or 42-Day "Waiting Period" options for Income Protection (Short Term). Select the option that best meets your needs.

			Bi-weekly Payroll Deduction for each Income Protection Option (Benefits Begin After)		
Annual Salary	**Gross Weekly Salary**	**Weekly Income Protection Benefit at 60% of Gross Weekly Salary**	**(14 days) Option 1**	**(28 days) Option 2**	**(42 days) Option 3**
$10,000	$192.31	$115.38	$2.23	$0.51	$0.27
$15,000	$288.46	$173.08	$3.34	$0.77	$0.40
$20,000	$384.62	$230.77	$4.45	$1.03	$0.53
$25,000	$480.77	$288.46	$5.57	$1.28	$0.66
$31,250	$600.97	$360.58	$6.96	$1.60	$0.83
$35,000	$673.08	$403.85	$7.79	$1.80	$0.93
$40,000	$769.23	$461.54	$8.91	$2.05	$1.06
$45,000	$865.38	$519.23	$10.02	$2.31	$1.19
$50,000	$961.54	$576.92	$11.13	$2.57	$1.33
$55,000	$1,057.69	$634.62	$12.25	$2.82	$1.46
$60,000	$1,153.85	$692.31	$13.36	$3.08	$1.59
$65,000	$1,250.00	$750.00	$14.48	$3.34	$1.73
$70,000	$1,346.15	$807.69	$15.59	$3.59	$1.86
$75,000	$1,442.31	$865.38	$16.70	$3.85	$1.99
$80,000	$1,538.46	$923.08	$17.82	$4.11	$2.12
$85,000	$1,634.62	$980.77	$18.93	$4.36	$2.26
$90,000	$1,730.77	$1,038.46	$20.04	$4.62	$2.39
$95,000	$1,826.92	$1,096.15	$21.16	$4.88	$2.52
$100,000	$1,923.08	$1,153.85	$22.27	$5.13	$2.65
Bi-weekly cost (24 pay deductions) per $10 of Weekly Benefit:			**$0.1930**	**$0.0445**	**$0.0230**