



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) <input type="radio"/> Standard POS <input type="radio"/> Premier POS <input type="radio"/> HDHP HSA <input type="radio"/> Out-of-Area PPO | <input type="radio"/> 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. <table style="width:100%"> <tr> <td style="width:50%"> ENROLL <input type="radio"/> Open Enrollment <input type="radio"/> New Hire (date of hire) _____ <input type="radio"/> COBRA (date of eligibility) _____ <input type="radio"/> Qualifying Event (description/date) _____ TERMINATE COVERAGE <input type="radio"/> Cancel Coverage </td> <td style="width:50%"> CHANGE <input type="radio"/> Add Dependent <input type="radio"/> Delete Dependent <input type="radio"/> Name Change (previous name) _____ <input type="radio"/> Plan Change <input type="radio"/> Address Change </td> </tr> </table> | ENROLL <input type="radio"/> Open Enrollment <input type="radio"/> New Hire (date of hire) _____ <input type="radio"/> COBRA (date of eligibility) _____ <input type="radio"/> Qualifying Event (description/date) _____ TERMINATE COVERAGE <input type="radio"/> Cancel Coverage | CHANGE <input type="radio"/> Add Dependent <input type="radio"/> Delete Dependent <input type="radio"/> Name Change (previous name) _____ <input type="radio"/> Plan Change <input type="radio"/> Address Change | MARITAL STATUS Please check one: <input type="radio"/> SINGLE <input type="radio"/> WIDOWED <input type="radio"/> MARRIED <input type="radio"/> DIVORCED | Does your spouse work full-time with Henrico County Government or Public Schools? <input type="radio"/> YES <input type="radio"/> NO If yes, please provide your spouse's name and organization: | SELECT CARDHOLDER (If both spouses are full-time employees) Please check one: SELF SPOUSE |
| ENROLL <input type="radio"/> Open Enrollment <input type="radio"/> New Hire (date of hire) _____ <input type="radio"/> COBRA (date of eligibility) _____ <input type="radio"/> Qualifying Event (description/date) _____ TERMINATE COVERAGE <input type="radio"/> Cancel Coverage | CHANGE <input type="radio"/> Add Dependent <input type="radio"/> Delete Dependent <input type="radio"/> Name Change (previous name) _____ <input type="radio"/> Plan Change <input type="radio"/> Address Change | | | | |

| | | | | | | | |
|------------|----------------|---------------|-----|---|---|------------|------------------------|
| LAST NAME | FIRST NAME | MI | SEX | M | F | BIRTH DATE | 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 |
|---|-----------------------------|---|--------------|-----------|------------------------|
| <input type="radio"/> Enroll <input type="radio"/> Delete | | <input type="radio"/> M <input type="radio"/> F | | | |
| <input type="radio"/> Enroll <input type="radio"/> Delete | | <input type="radio"/> M <input type="radio"/> F | | | |
| <input type="radio"/> Enroll <input type="radio"/> Delete | | <input type="radio"/> M <input type="radio"/> F | | | |
| <input type="radio"/> Enroll <input type="radio"/> Delete | | <input type="radio"/> M <input type="radio"/> 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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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): <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Line of Duty <input type="checkbox"/> Retiree | | Employee Type (choose one): <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-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 | <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of other group coverage | <input type="checkbox"/> Divorce | <input type="checkbox"/> No longer a dependent |
| | <input type="checkbox"/> Birth or adoption | <input type="checkbox"/> Death of spouse/dependent | <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | Date of Hire / / | Number of Hours Worked Per Week |
| Email Address | | | <input type="checkbox"/> 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 (check one) | Coverage Type (check one) |
| <input type="checkbox"/> Delta Dental PPO SM plus Premier <input type="checkbox"/> Delta Dental PPO SM - EPO Plan Design | <input type="checkbox"/> Low Option/Active <input type="checkbox"/> High Option/Active <input type="checkbox"/> EPO Plan Design/Active | <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> 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) |
|---|--------------------------|----------------|-----|--------------|--------------|----------------------------|
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> 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.



Plan Year: January 1, 2026 - December 31, 2026

**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.**
Your coverage effective date will be the first of the month following your hire date.

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 | Hire Date |

ANNUAL ELECTIONS

| Section 125 Benefit | Yes/No | Annual Election | # of Paychecks Remaining | Paycheck Deduction |
|--|-----------|-----------------|--------------------------|--------------------|
| Health Care FSA Maximum of \$3,300.00 per plan year | Yes No | \$ _____ | _____ | \$ _____ |
| Day Care FSA Maximum of \$7,500.00 per plan year (or \$3,750 if you're married and filing taxes separately) | Yes No | \$ _____ | _____ | \$ _____ |

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 |
|---|-------------|

Once you choose an annual contribution amount, Henrico County will deduct that amount pre-tax in equal parts from each paycheck. If you have unused funds in your Health Care FSA at the end of the year, you may roll over up to \$660 into the next calendar year. To continue participating, you must re-enroll each year during Open Enrollment and make a new annual election.

You are not eligible to enroll in the health care flexible spending account benefit if you are enrolled in a high-deductible health plan.

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 \$660 will be rolled over to the subsequent plan year. Any Health Care FSA funds more than \$660 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

To help estimate your payroll deduction and choose the appropriate waiting period, refer to the informational pages that follow this form.

Personal Information:

Name: _____

Social Security #: _____

Hire Date: _____

Coverage Effective Date: _____

Your coverage effective date will be the first of the month following your hire 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 _____

2026 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 |