

# Commonwealth of Virginia Health Benefits Program

## Extended Coverage Enrollment Form

Extended Coverage participants/qualified beneficiaries should use this form to enroll or make allowable changes to their health plan coverage. Refer to your Election Notice for information regarding your Extended Coverage rights and responsibilities.

### PART A: Enrollee Information

PLEASE PRINT

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
First Name M.I. Last Name

Address \_\_\_\_\_  
Street City State Zip + 4

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Sex:  Male  Female Date of Birth \_\_\_\_\_  
MM/DD/YYYY

### PART B: Initial Enrollment

#### Qualifying Event (Check one)

- Termination of Employment  Reduction in Hours (includes leave without pay and VSDP long-term disability)  Loss of Dependent Child Eligibility  
 Divorce  Death of the Employee  
Date Of Qualifying Event \_\_\_\_\_  Military Leave

**For initial Extended Coverage enrollment, return this Enrollment Form and your Election Form (included with your Election Notice) to the address provided in your Election Notice.**

### PART C: Requesting Changes To Membership

Once enrolled, you may change your plan and/or type of membership during the annual Open Enrollment (non-Medicare plans only) or within 31 days of a consistent qualifying mid-year event which permits an election change.

- Open Enrollment Change  
 Terminate Extended Coverage for All Family Members  
 Other Membership Changes Outside Open Enrollment

#### Dependent(s) affected by election change:

Add Dependents (Names) \_\_\_\_\_

Remove Dependents (Names) \_\_\_\_\_

**QUALIFYING MID-YEAR EVENT** – Indicate reason for the membership change from the lists of events below, and attach documentation to support the event.

Date of event: \_\_\_\_\_  
Month/Day/Year

- |   |   |
|---|---|
| <input type="checkbox"/> Birth or adoption (15)                             | <input type="checkbox"/> Marriage (07)  |
| <input type="checkbox"/> Change from full-time to part-time employment (77) | <input type="checkbox"/> Open enrollment or change allowed by another employer (62) |
| <input type="checkbox"/> Change from part-time to full-time employment (78) | <input type="checkbox"/> Permanent custody of a child (72)                          |
| <input type="checkbox"/> Death of child (17)                                | <input type="checkbox"/> Unpaid leave for spouse (64)                               |
| <input type="checkbox"/> Death of spouse (08)                               | <input type="checkbox"/> Unpaid leave ended for spouse (63)                         |
| <input type="checkbox"/> Gained entitlement to Medicaid (66)                | <input type="checkbox"/> Child ceases to be eligible/second qualifying event (38)*  |
| <input type="checkbox"/> Judgment, decree or order to add child (71)        | <input type="checkbox"/> Divorce/second qualifying event*                           |
| <input type="checkbox"/> Judgment, decree or order to remove child (67)     | <input type="checkbox"/> Enrolled in other group health plan coverage*              |
| <input type="checkbox"/> Lost another government-sponsored plan (76)        | <input type="checkbox"/> Gained entitlement to Medicare (66)*                       |
| <input type="checkbox"/> Lost employer eligibility (13)                     | <input type="checkbox"/> Determined disabled by Social Security Administration*     |
| <input type="checkbox"/> Lost Medicare or Medicaid (09)                     | <input type="checkbox"/> Ceased to be disabled during disability extension*         |
|   | <input type="checkbox"/> Death of former employee/second qualifying event*          |

\* See your Election Notice for additional information regarding these events

**To request this change, return this Enrollment Form to the Office of Health Benefits Extended Coverage Administration at 101 North 14th Street, 13th Floor, Richmond, VA 23219.**

## PART D: Health Coverage

### I. TYPE OF MEMBERSHIP (Check one and list in Section III. below)

Single       Enrollee Plus One       Family

Is this a change in membership?  Yes  No

### II. HEALTH PLAN

(Check One)

#### Self-Funded Statewide Plans

Administered by the State Health Benefits Program

COVA HDHP High Deductible Health Plan (CHD)

- COVA Care (with basic dental) (CC0)
- COVA Care + Out-of-Network (CC1)
- COVA Care + Expanded Dental (CC2)
- COVA Care + Out-of-Network + Expanded Dental (CC3)
- COVA Care + Expanded Dental + Vision & Hearing (CC4)
- COVA Care + Out-of-Network + Expanded Dental + Vision & Hearing (CC5)

#### Regional Fully Insured HMO (Northern Virginia)

Kaiser Permanente HMO (KP)

*Note: Kaiser plan members must select a primary care physician.*

Medicare-Coordinating Plan (existing participants only): Plan Name \_\_\_\_\_

### III. FAMILY MEMBERS TO BE COVERED (list all)

Type of Qualifying Beneficiary (QB): H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF= other female child\* OM=other male child\*

NAME PLEASE PRINT (include last name if different)	BIRTHDATE MM/DD/YYYY	SOCIAL SECURITY NUMBER	QB TYPE (SEE ABOVE)
Spouse			
Children			

*If you need more space, list additional children on a separate sheet of paper and attach to this Form.*

\*Attach explanation. Eligibility must be verified by your Benefits Administrator.

## PART E: Certification

**ENROLLEE STATEMENT:** I want to enroll or make a change in Extended Coverage. I understand that I will be billed directly for the monthly premium. Once enrolled, I understand that changes may only be made at Open Enrollment or with certain qualifying mid-year events (see Part C) when the changes are consistent with the events. I have read and understand my rights and responsibilities as explained in my Election Notice. I understand that my premiums are subject to change and 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 just as those requirements apply to similarly-situated non-Extended Coverage health plan participants. I understand that non-payment of premium will result in cancellation of coverage per the provisions of the Public Health Service Act as described in my Election Notice and that claims will not be processed during the defined grace period. Further, I understand that no claims will be processed for services during months for which premium payment in full has not been received.

**CERTIFICATION/AUTHORIZATION:** I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, 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 operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sign Here \_\_\_\_\_ Date \_\_\_\_\_

## Agency Approval/Verification For Initial Enrollment

Number of months for Extended Coverage: \_\_\_\_\_

I certify that I have reviewed this Extended Coverage Enrollment Form and that it is complete and accurate to the best of my knowledge.

Agency Representative's Signature \_\_\_\_\_ Date Received \_\_\_\_\_  
MM/DD/YYYY

Print Name and Title \_\_\_\_\_ Phone No. \_\_\_\_\_

Agency Name \_\_\_\_\_ Agency No. \_\_\_\_\_ Effective Date \_\_\_\_\_  
MM/DD/YYYY