Elective Group Health Plan Opt-in Form

Each self-funded group health plan specified in § 38.2-3445.06 A of the Code of Virginia and self-funded coverage specified in § 38.2-3445.06 C of the Code of Virginia may opt-in to the balance billing and arbitration requirements set forth in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia. Such a plan is known as an "elective group health plan."

Complete and **submit this form electronically** to the Virginia State Corporation Commission Bureau of Insurance at BBVA@scc.virginia.gov for each health plan offered by the sponsor with a unique Group Identification Number.

This form must be submitted at least **30 days in advance** of the effective date of the election to participate. The effective date for participation must be **January 1** of any year or the **first day of the group health plan's plan year.**

The effective date for termination must be **December 31** of any year or the **last day of the group health plan's plan year.**

Elective Group Health Plan Information

Please indicate that the elective group health plan is either a (*check one*):

☐ self-funded ERISA plan ☐ self-funded non-ERISA local government or schools plan

The group health plan must be one of these two types of plans to be eligible to opt in.

Health Plan Name: _____

Number of covered lives in Virginia enrolled in your plan: _____

Group Identification Number: _____

Employer/Sponsor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Designated contact name for inquiries: _____

Phone: _____ Email: _____

Opt-in duration:

☐ One year

☐ Automatic renewal (continuous until terminated by providing notice at least 30 days prior to the end of a calendar year or plan year)

Opt-in effective date:_____ **(**must be **January 1** or the **first day of the plan year)**

Your Contact Information (person completing the form)

Name: _____

Phone: _____ Email: _____

Are you the third-party administrator ("TPA") or do you self-administer the elective group health plan? ☐Yes ☐ No *If "No," the administrator must be notified of the decisions identified on this form prior to submission. Provide the name of the person at the TPA contacted and the contact method:*

Please provide the name of person contacted at the TPA: _____

Contact was made by: ___ phone ____ email ____ other (explain) _____

Third-party Administrator Information

*If you self-administer, please include your own information.

Administrator (Company) Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Name of designated contact for inquiries: _____

Phone: _____ Email: _____

Elective Group Health Plan Opt-in Attestation

CERTIFICATION:

By submission of this form, _____ (name of employer/sponsor) hereby elects _____ (name of health plan) to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules. _____ (name of employer/sponsor) consents to have the information included in this submission appear in the directory of elective group health plans posted on the website of the State Corporation Commission Bureau of Insurance.

I, _____ (name of authorized representative), attest that I have been designated by _____ (employer/sponsor name) to elect _____ (name of health plan) to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules.

Signature _____

Title _____

Date _____