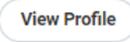
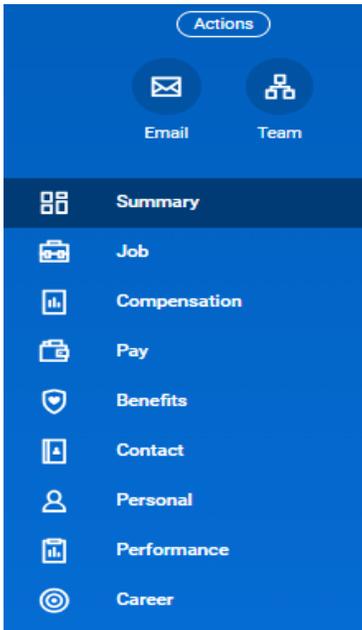


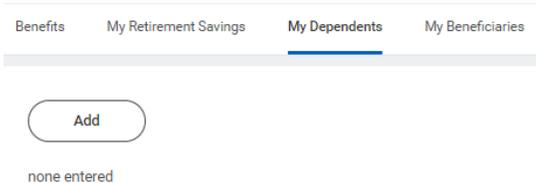
New Hire Enrollment in Workday –

ADD YOUR DEPENDENTS FIRST

Click on your Picture & select  the select Benefits



Under the My Dependents tab, click Add -



Before you add your Dependent to the system, please ensure you have all documents listed below to add them to your plans. If you are covering your spouse & asking for a waiver, the list of eligible documents for that process are listed within the Spousal Privilege Premium Waiver process.

Add My Dependent



When adding dependents, we ask you to provide the following documentation:

[For Spouse/Same Sex Spouse](#) – Copy of marriage license or civil union license', social security card and current Federal 1040 Income Tax Return filing status of Married Filing Jointly or Separately &/or listing of claimed dependent(s). Confidential financial information can be redacted.

[For Children/Adult Children](#) – Copy of birth certificate, adoption agreement or placement for adoption, court custody or guardianship document, divorce decree or other court documents requiring you to provide medical coverage, social security card(s) and current Federal 1040 Income Tax Return filing status of Married Filing Jointly or Separately &/or listing of claimed dependent(s). Confidential financial information can be redacted.

Dependent Options

Effective Date & Reason

Effective Date *

10/09/2023



Reason

Add Dependent > New Employee adding Dependents

Use your new dependent as a beneficiary?

Use as Beneficiary

Yes



Dependent Personal Information

Legal Name

Legal Name *

(empty)



Gender

Gender *

(empty)



Date of Birth

Date of Birth *

(empty)



Citizenship

Citizenship Status

(empty)



Relationship

Relationship *

(empty)



Is this a person with a disability?

Disabled

No



Dependent Personal Information

Legal Name

Name

(empty)



Country *

x United States of America

Allow Duplicate Name

Check this box only when there is more than one dependent with the same name.

Prefix

First Name *

Willy

Middle Name

Wally

Last Name *

Wonka

Suffix

Contact Information

Primary Address

Add

Additional Address

Add

Primary Phone

Add

Primary Email

Add

Identifier Information

National IDs

Add

Other IDs

Add

Identifier Information

National IDs

Country *



× United States of America

National ID Type *

× Social Security Number (SSN)

Add/Edit ID *

123-45-6789

enter your comment



Adding Spouse for Benefits & as a Beneficiary

Attachments

Drop files here

or

Select files

Attachments



Using for Catch_Deps in AI-CI-HI-SL.docx

✓ Successfully Uploaded!

Description

Marriage Certificate

Category *

× Benefits

Submit

Save for Later

Cancel

Benefits My Retirement Savings **My Dependents**

Success! Event submitted

[View Details](#)

Add

Dependents 1 item

| Dependent | Relationship | Age | |
|-----------------------------|--------------|-----------------------------|---------------------------------------|
| Willy Wonka | Spouse | 73 years, 1 months, 11 days | Delete Edit |

Dependent Personal Information

Legal Name

Name ↶ ✓
(empty)

Country *

Allow Duplicate Name

 Check this box only when there is more than one dependent with the same name.

Prefix

First Name *

Middle Name

Last Name *

Suffix

Benefits My Retirement Savings **My Dependents**

You have submitted

[View Details](#)

Add

Dependents 2 items 🔍 📄 🗑️ 📄 📄 📄

| Dependent | Relationship | Age | |
|-----------------------------|--------------|-----------------------------|---------------------------------------|
| Cindy Who | Child | 3 years, 1 months, 11 days | Delete Edit |
| Willy Wonka | Spouse | 73 years, 1 months, 11 days | Delete Edit |

From your **Welcome** Screen in the **Awaiting Your Action** section, please select

[Go to All Inbox Items](#)

Change Benefit Elections

10 hour(s) ago - Effective 10/02/2023

Initiated On 10/02/2023

Submit Elections By 10/31/2023

[Let's Get Started](#)

Update Your Information

Health Information

Tobacco Use

Question Have you OR any of your dependents in your household used Tobacco in the past 12 months?

Answer * Yes
 No

[Continue](#)

[Cancel](#)

Information Updated

Thanks for updating your information.

Next up, you'll confirm benefits you'd like to keep the same, or add any changes you'd like to make.

[Continue](#)

[Cancel](#)

Start Selecting your Benefits!

MENU



Search



New Hire

Projected Total Cost Per Paycheck
\$0.00

Projected Total Credits
\$0.00

Health Care and Accounts

| | | |
|---|---|--|
| Medical, Vision & RX Waived Enroll | Spousal Privilege Premium Waiver Waived Enroll | Dental Waived Enroll |
| Hospital Indemnity Waived Enroll | Accident Insurance Waived Enroll | Critical Illness Waived Enroll |
| Health Savings Account Waived Enroll | Medical FSA Waived Enroll | Limited Purpose FSA Waived Enroll |
| Dependent Care FSA Waived Enroll | | |

Insurance

| | | |
|--|---|---|
| Basic Life & AD&D MetLife Insurance Company 1x (Employee) Cost per paycheck: Included Coverage: 1 X Salary Manage | Supplemental Life & AD&D Waived Enroll | Spouse Life & AD&D Waived Enroll |
| Child Life & AD&D Waived Enroll | Short Term Disability (STD) Waived Enroll | Long Term Disability (LTD) Waived Enroll |

Additional Benefits

| | | |
|--|---|---|
| Employee Assistance Program Sunstone Counseling Cost per paycheck: Included Manage | Cafe Waived Enroll | Legal Assistance Waived Enroll |
|--|---|---|

[Review and Sign](#)

[Save for Later](#)

Medical, Vision & RX

Projected Total Cost Per Paycheck
\$0.00

Plans Available

Select a plan or Waive to opt out of Medical, Vision & RX. The displayed cost of waived plans assumes coverage for Employee Only.

4 items ☰ ☰ ↗

| *Selection | Benefit Plan Details | You Pay (Biweekly) |
|--|---|--------------------|
| <input type="radio"/> Select <input checked="" type="radio"/> Waive | CareFirst Administrators BC/BS HDHP | \$65.66 |
| <input checked="" type="radio"/> Select <input type="radio"/> Waive | CareFirst Administrators BC/BS PPO 2 | \$142.04 |
| <input type="radio"/> Select <input checked="" type="radio"/> Waive | CareFirst Administrators BC/BS PPO VHC PPO | \$260.44 |
| <input type="radio"/> Select <input checked="" type="radio"/> Waive | Kaiser Permanente HMO | \$230.50 |

PLEASE WAIVE SPOUSAL SURCHARGE IF YOU ARE NOT ELECTING MEDICAL COVERAGE

You will notice that the **Projected Total Cost Per Paycheck** will change from Employee Only to whatever Coverage Level you select. In the examples below the cost goes from \$130.22 (Employee Only) to \$321.73 (Employee + Spouse) to \$455.22 (Family).

Medical, Vision & RX - CareFirst Administrators BC/BS PPO VHC PPO New Hire for Silly Dogooder (30041) ☰

Projected Total Cost Per Paycheck \$130.22 Projected Total Credits \$0.00

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage * Employee Only

Plan cost per paycheck \$130.22

2 items ☰ ☰ ↗

| Select | Dependent | Relationship | Date of Birth |
|--------------------------|-------------|--------------|---------------|
| <input type="checkbox"/> | Willy Wonka | Spouse | 09/01/1950 |
| <input type="checkbox"/> | Cindy Who | Child | 09/01/2020 |

Health Care Instructions

Provider Website [CareFirst Administrators](#)

General Instructions

Medical, Vision & RX - CareFirst Administrators BC/BS PPO VHC PPO

New Hire for Silly Dogooder (30041) ⋮

Projected Total Cost Per Paycheck
\$321.73

Projected Total Credits
\$0.00

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage * Employee + Spouse

Plan cost per paycheck \$321.73

[Add New Dependent](#)

2 items



| Select | Dependent | Relationship | Date of Birth |
|-------------------------------------|-------------|--------------|---------------|
| <input checked="" type="checkbox"/> | Willy Wonka | Spouse | 09/01/1950 |
| <input type="checkbox"/> | Cindy Who | Child | 09/01/2020 |

Health Care Instructions

Provider Website [CareFirst Administrators](#)

General Instructions

Medical, Vision & RX - CareFirst Administrators BC/BS PPO VHC PPO

New Hire for Silly Dogooder (30041) ⋮

Projected Total Cost Per Paycheck
\$455.22

Projected Total Credits
\$0.00

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage * Employee + Family

Plan cost per paycheck \$455.22

[Add New Dependent](#)

2 items



| Select | Dependent | Relationship | Date of Birth |
|-------------------------------------|-------------|--------------|---------------|
| <input checked="" type="checkbox"/> | Willy Wonka | Spouse | 09/01/1950 |
| <input checked="" type="checkbox"/> | Cindy Who | Child | 09/01/2020 |

Health Care Instructions

Provider Website [CareFirst Administrators](#)

General Instructions

You are able to add a dependent here as well, but you will not be able to select **Use as Beneficiary**

The process to add is also little different from adding your dependent before you enrollment starts.

Add Dependent

Relationship *

Use as Dependent

Use as Beneficiary

Inactive Date (empty)

Date of Birth * 

Age (empty)

Gender *

Citizenship Status

Disabled

Allow Duplicate Name

Check this box only when there is more than one dependent with the same name.

Legal Name Contact Information National IDs Additional Government IDs Other IDs

Country *

Prefix

First Name *

Middle Name

Last Name *

Suffix

Phone

Add

Address

Use Existing Address

Search 

All >

By Contact >

Country *

Address Line 1 *

Address Line 2

City *

State *

Postal Code *

County

Usage

Type *

Home 

Primary Work

Primary Home

National IDs 1 item

| | *Country | *National ID Type | Current ID | Add/Edit ID | Issued Date | Expiration Date | Issued By | Series |
|---|---|---|------------|-------------------------------|---|---|-----------|--------|
|  | <input type="text" value="United States of America"/>  | <input type="text" value="Social Security Number (SSN)"/>  | | <input type="text" value=""/> | <input type="text" value="MM/DD/YYYY"/>  | <input type="text" value="MM/DD/YYYY"/>  | | |

Save

Cancel

SPOUSAL PRIVILEGE PREMIUM WAIVER Process – If you're enrolling in a Medical Plan, change the selection from Waive to Select

Spousal Privilege Premium Waiver New Hire for ☰

Projected Total Cost Per Paycheck
\$430.84

Plans Available

Select a plan or Waive to opt out of Spousal Privilege Premium Waiver. The displayed cost of waived plans assumes coverage for Employee Only.

1 item ☰ ☰ ☰

| *Selection | Benefit Plan Details | You Pay (Biweekly) |
|--|----------------------|--------------------|
| <input checked="" type="radio"/> Select <input type="radio"/> Waive | SPS | Included |

Health Care Instructions

General Instructions

****PLEASE WAIVE SPOUSAL SURCHARGE IF YOU ARE NOT ELECTING MEDICAL COVERAGE****

Required Documentations based on Coverage elections:

- Does not apply. I'm NOT covering a spouse: No documentation is required. No surcharge will be applied
- My spouse is offered healthcare elsewhere. I understand a spousal surcharge will be applied: No documentation is needed. You'll be charged **\$300.00 monthly**.
- My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer: A copy of the most recent 1040 Federal or State Tax Return verifying filing status of Married Filing Jointly or Separately and a letter from your spouse's Human Resource or Benefits Department, on company letterhead (with a contact person's name and telephone number other than your spouse), that states your spouse is not offered employer group health benefits.
- My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits: A copy of the most recent 1040 Federal or State Tax Return Verifying Filing Status of Married Filing Jointly or Separately verifying your spouse & their employment status included on the signed portion of the return which contains the signature & occupation for you & your spouse. All other information on the tax return can be redacted (blacked out). On Federal Form 1040, this information is found at the top of page 1 (member's name and spouse's name) and the bottom of page 2 (employee's & spouse's signature and occupations). If the unemployed spouse files a **MARRIED FILING SEPARATE 1040** Tax Return, they must submit their return showing the same information as stated above. If your spouse became unemployed or retired after the most recent federal tax return was filed, employee must submit that return and your signed statement that verifies your spouse is currently unemployed or retired and not covered or eligible under any other employer group health benefits or applicable supporting documentation of unemployment or retirement such as a Separation agreement, COBRA notice or Letter of Retirement from employer.
- My spouse is self-employed and is not covered or eligible under any other employer group health benefits: A copy of the most recent State or 1040 Federal Tax Return & one of the following: a. Schedule SE (Self-Employment Tax), b. Sole Proprietor - Schedule C or Form 1040-ES, c. Partnership - Form 1065 d. Corporations - Form 1120 or Form 1120-S, e. Form 941 (Employer's Quarterly Federal Tax Return), f. Form 940 (Employer's Annual Federal Unemployment Tax Return)
- Spouse is currently employed through Virginia Hospital Center: Email yours & your spouse's Full Name and VHC employee ID #s to Benefits.Department@VirginiaHospitalCenter.com

****IF YOU HAVE DOCUMENTS PLEASE ATTACH TO THE REVIEW AND SIGN****

Confirm and Continue

Cancel

If you are not covering a spouse select the 1st option, otherwise please select the right category for your situation

Spousal Privilege Premium Waiver - SPS New Hire for Christina Choi ☰

Projected Total Cost Per Paycheck
\$430.84

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage ☰ ☰ ☰

Plan cost per paycheck

Does not apply. I'm NOT covering a spouse.

My spouse is offered healthcare elsewhere. I understand a spousal surcharge will be applied.

My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer.

My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits.

My spouse is self-employed and is not covered or eligible under any other employer group health benefits.

My spouse is currently employed through VHC Health.

1 item ☰ ☰ ☰

| Select | Dependent | Relationship | Date of Birth |
|--------------------------|-----------|--------------|---------------|
| <input type="checkbox"/> | Test | Spouse | 09/27/1981 |

Health Care Instructions

General Instructions

****PLEASE WAIVE SPOUSAL SURCHARGE IF YOU ARE NOT ELECTING MEDICAL COVERAGE****

Required Documentations based on Coverage elections:

- Does not apply. I'm NOT covering a spouse: No documentation is required. No surcharge will be applied
- My spouse is offered healthcare elsewhere. I understand a spousal surcharge will be applied: No documentation is needed. You'll be charged **\$300.00 monthly**.
- My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer: A copy of the most recent 1040 Federal or State Tax Return verifying filing status of Married Filing Jointly or Separately and a letter from your spouse's Human Resource or Benefits Department, on company letterhead (with a contact person's name and telephone number other than your spouse), that states your spouse is not offered employer group health benefits.
- My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits: A copy of the most recent 1040 Federal or State Tax Return Verifying Filing Status of Married Filing Jointly or Separately verifying your spouse & their employment status included on the signed portion of the return which contains the signature & occupation for you & your spouse. All other information on the tax return can be redacted (blacked out). On Federal Form 1040, this information is found at the top of page 1 (member's name and spouse's name) and the bottom of page 2 (employee's & spouse's signature and occupations). If the unemployed spouse files a **MARRIED FILING SEPARATE 1040** Tax Return, they must submit their return showing the same information as stated above. If your spouse became unemployed or retired after the most recent federal tax return was filed, employee must submit that return and your signed statement that verifies your spouse is currently unemployed or retired and not covered or eligible under any other employer group health benefits or applicable supporting documentation of unemployment or retirement such as a Separation agreement, COBRA notice or Letter of Retirement from employer.
- My spouse is self-employed and is not covered or eligible under any other employer group health benefits: A copy of the most recent State or 1040 Federal Tax Return & one of the following: a. Schedule SE (Self-Employment Tax), b. Sole Proprietor - Schedule C or Form 1040-ES, c. Partnership - Form 1065 d. Corporations - Form 1120 or Form 1120-S, e. Form 941 (Employer's Quarterly Federal Tax Return), f. Form 940 (Employer's Annual Federal Unemployment Tax Return)
- Spouse is currently employed through Virginia Hospital Center: Email yours & your spouse's Full Name and VHC employee ID #s to Benefits.Department@VirginiaHospitalCenter.com

****IF YOU HAVE DOCUMENTS PLEASE ATTACH TO THE REVIEW AND SIGN****

Save

Cancel

Spousal Privilege Premium Waiver - SPS New Hire for Silly Dogooder (30041)

Projected Total Cost Per Paycheck \$455.22
 Projected Total Credits \$0.00

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage * × My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer.

Plan cost per paycheck

[Add New Dependent](#)

2 items

| Select | Dependent | Relationship | Date of Birth |
|--------------------------|-------------|--------------|---------------|
| <input type="checkbox"/> | Willy Wonka | Spouse | 09/01/1990 |
| <input type="checkbox"/> | Cindy Who | Child | 09/01/2020 |

[Save](#) [Cancel](#)

Health Care Instructions

General Instructions

Required Documentations based on Coverage elections:

- **Does not apply. I'm NOT covering a spouse:** No documentation is required. No surcharge will be applied
- **My spouse is offered healthcare elsewhere. I understand a spousal surcharge will be applied:** No documentation is needed. You'll be charged **\$300.00 monthly**.
- **My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer:** A copy of the most recent 1040 Federal or State Tax Return verifying filing status of Married Filing Jointly or Separately and a letter from your spouse's Human Resource or Benefits Department, on company letterhead [with a contact person's name and telephone number other than your spouse], that states your spouse is not offered employer group health benefits.
- **My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits:** A copy of the most recent 1040 Federal or State Tax Return Verifying Filing Status of Married Filing Jointly or Separately verifying your spouse & their employment status included on the signed portion of the return which contains the signature & occupation for you & your spouse. All other information on the tax return can be redacted (blacked out). On Federal Form 1040, this information is found at the top of page 1 (member's name and spouse's name) and the bottom of page 2 (employee's & spouse's signature and occupations). If the unemployed spouse files a MARRIED FILING SEPARATE 1040 Tax Return, they must submit their return showing the same information as stated above. If your spouse became unemployed or retired after the most recent federal tax return was filed, employee must submit that return and your signed statement that verifies your spouse is currently unemployed or retired and not covered or eligible under any other employer group health benefits or applicable supporting documentation of unemployment or retirement such as a Separation agreement, COBRA notice or Letter of Retirement from employer.
- **My spouse is self-employed and is not covered or eligible under any other employer group health benefits:** A copy of the most recent State or 1040 Federal Tax Return and once of the following: a. *Schedule SE (Self-Employment Tax)*, b. *Sole Proprietor - Schedule C or Form 1040 - ES*, c. *Partnership - Form 1065*, d. *Corporations - Form 1120 or Form 1120-S*, e. *Form 941 (Employer's Quarterly Federal Tax Return)*, f. *Form 940 (Employer's Annual Federal Unemployment Tax Return)*
- **Spouse is currently employed through Virginia Hospital Center:** Email yours & your spouse's Full Name and VHC employee ID # to

MENU



New Hire New Hire for Silly Dogooder (30041)

Projected Total Cost Per Paycheck \$455.22
 Projected Total Credits \$0.00

Health Care and Accounts

UPDATED

Medical, Vision & RX
 CareFirst Administrators BC/BS PPO VHC PPO

Cost per paycheck \$455.22

Coverage Employee + Family

Dependents 2

[Manage](#)

UPDATED

Spousal Privilege Premium Waiver
 SPS

Cost per paycheck Included

Coverage My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer.

[Manage](#)

Continue to select the benefits you want to enroll in. You do not have to **Manage** any benefit you wish to **WAIVE**.

Additional Benefits

UPDATED

Employee Assistance Program
 Sunstone Counseling

Cost per paycheck Included

[Manage](#)

UPDATED

Cafe
 VHC

Cost per paycheck Included

[Manage](#)

UPDATED

Legal Assistance
 MetLife Insurance Company

Cost per paycheck \$8.31

[Manage](#)

[Review and Sign](#) [Save for Later](#)

Once you've selected everything you want to enroll in, please select **Review and Sign**

View Summary

Projected Total Cost Per Paycheck \$240.24
Projected Total Credits \$0.00

****ADD BENEFIT ELECTION REVIEW LANGUAGE HERE****

| Plan | Coverage Begin Date | Deduction Begin Date | Coverage | Dependents | Beneficiaries | Cost |
|--|---------------------|----------------------|--|------------|---------------|----------|
| Medical, Vision & RX CareFirst Administrators BC/BS PPO 2 | 11/01/2023 | 11/01/2023 | Employee + Child(ren) | Test Test | | \$194.12 |
| Spousal Privilege Premium Waiver SPS | 11/01/2023 | 11/01/2023 | Does not apply. I'm NOT covering a spouse. | | | Included |
| Dental Delta Dental | 11/01/2023 | 11/01/2023 | Employee + Child(ren) | Test Test | | \$57.81 |
| Basic Life & AD&D MetLife Insurance Company 1x (Employee) | 11/01/2023 | 11/01/2023 | 1 X Salary | | | Included |
| Employee Assistance Program Sunstone Counseling | 11/01/2023 | 11/01/2023 | | | | Included |
| Care VHC | 10/02/2023 | 10/02/2023 | | | | Included |
| Legal Assistance MetLife Insurance Company | 11/01/2023 | 11/01/2023 | | | | \$8.31 |

| Waived Benefits | 12 Items |
|-----------------------------|----------|
| Hospital Indemnity | Waived |
| Accident Insurance | Waived |
| Critical Illness | Waived |
| Health Savings Account | Waived |
| Medical FSA | Waived |
| Limited Purpose FSA | Waived |
| Dependent Care FSA | Waived |
| Supplemental Life & AD&D | Waived |
| Spouse Life & AD&D | Waived |
| Child Life & AD&D | Waived |
| Short Term Disability (STD) | Waived |
| Long Term Disability (LTD) | Waived |

| Total Benefits Cost | 1 Item | |
|---------------------|---------|----------|
| Employee Cost | Credits | Net Cost |
| \$240.24 | \$0.00 | \$240.24 |

When you add a dependent (Spouse &/or Dependents), you MUST attached the required documents to be able to add them to your plans during the enrollment process.

Attachments

Drop files here

or

Select files

Electronic Signature

Legal Notice: Please Read

Your name and Password are considered your "Electronic Signature" and will serve as your confirmation of the accuracy of the information being submitted. When you check the "I Agree" checkbox, you are certifying that:

- 1. General Acknowledgment:** I am applying to enroll in the benefit option(s) selected by me pursuant to this Workday self-service benefits online enrollment system. I have read and understand this enrollment form and declare that all the information given is true and complete to the best of my knowledge and belief. Virginia Hospital Center Health System has provided or made available documentation related to the benefit option subject to this enrollment. I have read and understand the plan documents and/or plan related materials, and I understand that my and my eligible dependents receipt of benefits or benefits coverage pursuant to the benefit option(s) selected by me pursuant to this enrollment form shall be subject in all respects to the terms, conditions, and requirements of the plan documents applicable to such benefit options.
- 2. Deduction Authorization and Premium Reimbursement:** I authorize Virginia Hospital Center Health System to take any and all applicable deductions from my paychecks, on a pre-tax or after tax basis as appropriate, and to pay such sums as are due to the applicable carriers or providers for the benefit option(s) selected by me pursuant to this enrollment form. To the extent that I or my eligible dependents receive benefits or benefits coverage for which I have not paid the applicable premiums or other applicable employee-paid costs and acknowledge that Virginia Hospital Center Health System shall have the right to and shall be authorized to require me to tender a cash payment for such reimbursement or to deduct such reimbursement from payments of any kind otherwise due to me from Virginia Hospital Center Health System. **In addition, if you are a part-time (less than 20 hours per week) or PRN employee or terminate employment with Virginia Hospital Center Health System and premiums are unable to be collected from your paycheck due to a lack of hours worked, you understand benefits will be terminated on the last day of the month and you will responsible for payment of any missed premiums.**
- 3. Employee Eligibility:** I currently meet the applicable eligibility requirements of each benefit option selected by me pursuant to this enrollment form.
- 4. Employee Responsibility:** I understand that it is my responsibility, and not the responsibility of Virginia Hospital Center Health System, to check my paychecks or paystubs to ensure that proper deductions are being applied accurately for my requested benefit option(s) and to ensure that I am enrolled in the proper benefit option(s).
- 5. Employee Period:** I understand that I must timely complete this enrollment form to enroll in one or more of the benefit options subject to this enrollment form. I acknowledge that the only time I can enroll, add dependents, drop dependents, and/or change plans pursuant to this enrollment form is during the open enrollment period each year, unless I experience an earlier qualifying event and I timely make and submit such change to Virginia Hospital Center Health System.
- 6. Fraud Warnings:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for benefits or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.
- 7. Spousal Privilege Premium (SPP):** If you have a spouse enrolled in one of Virginia Hospital Center Health System health plan options, you will be subject to an additional Spousal Premium fee, unless you have been notified that your waiver application has been approved. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System benefits open enrollment. **The Spousal Privilege Premium stays in effect through the benefit plan year unless you have a qualifying event to remove your spouse from your VHC health insurance plan.**

I Accept

enter your comment

Submit

Save for Later

Cancel

Once your documents are attached & you accept the Legal Notice for your Electronic Signature, your elections will be reviewed for final confirmation.