



BAR CODE

**COMMONWEALTH OF VIRGINIA**  
**DEPARTMENT OF HUMAN RESOURCE MANAGEMENT**

SARA REDDING WILSON  
DIRECTOR

James Monroe Building  
101 N 14<sup>th</sup> Street  
Richmond, Virginia 23219

**STATE HEALTH BENEFITS PROGRAM**  
**Dependent Eligibility Audit Final Disposition**

[Date]

[Employee Name]

[Employee Address][Employee Address 2]

[City, State Zip][Country]

Dear [Employee Name],

You are receiving this letter because you either did not respond with a Required Affidavit Signature Form or you provided incomplete information for one or more of your dependents during the recent Commonwealth of Virginia Dependent Eligibility Verification Audit. Please see the chart below for specific information.

**As indicated in our previous correspondence, failure to respond to the audit or to provide a completed Required Affidavit Signature Form verifying the eligibility of your dependent(s) has resulted in our classifying your dependent(s) as ineligible for coverage under the Commonwealth of Virginia health plans.**

Dependent Name	Relationship	Status
<b>JOHN DOE</b> 08/07/1991	Children	Dependent to be terminated. Claims will be retracted back to July 1, 2009.
<b>JANE DOE</b> 10/30/1999	Children	Dependent to be terminated. Claims will be retracted back to July 1, 2009.
<b>JANET DOE</b> 11/21/1988	Children	Dependent to be terminated. Claims will be retracted back to July 1, 2009.
<b>TED DOE</b> 04/30/1960	Spouse	Dependent to be terminated. Claims will be retracted back to July 1, 2009.

1VAC55-20 of the Virginia Administrative Code provides regulations which govern the Health Benefits Plan for State Employees (the Plan). Section 20-210 states that an employee who includes an ineligible dependent may be excluded from participation in the Program for a period of up to three years. Since you have failed to provide the necessary completed Required Affidavit Signature Form, you and all your covered dependents will be removed from coverage for a period of three years effective January 1, 2010. Furthermore, all claims paid for your ineligible dependents, except for pharmacy prescriptions, will be retracted back to July 1, 2009. However, if you provide the necessary completed Required Affidavit Signature Form by December 11, 2009, then this suspension from the Plan may be lifted.

If you wish to file for an exception, please complete the enclosed Required Affidavit Signature Form and send to the Commonwealth of Virginia Dependent Eligibility Verification Unit at PO Box 3005, Arlington Heights, IL 60006-9923 in the enclosed, postage paid return envelope. Your exception request **MUST BE RECEIVED BY December 11, 2009**. If you have additional questions, you may contact the Dependent Eligibility Verification Unit at 1-866-641-5651 and enter 8513 when prompted for your Employer's Identification Number.

Commonwealth of Virginia Dependent Eligibility Verification Unit

Dependent Eligibility Verification Unit  
1-866-641-5651, code 8513



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EXCEPTIONS REQUEST - REQUIRED AFFIDAVIT
SIGNATURE FORM

Instructions:

- 1) Carefully read the entire contents of this packet.
2) Review the list of dependents shown on page two of this form.
a. Contact your agency Benefits Administrator immediately if a dependent's name, relationship, or date of birth is incorrect...
b. Check the correct eligibility status for each dependent shown using the eligibility rules found in the Eligibility Definitions insert in this packet.
c. Sign and date this form. Include your daytime phone number.
3) Mail your signed EXCEPTIONS form in the enclosed envelope. It must be postmarked no later than December 11, 2009.

Mailing Address:
Dependent Eligibility Verification Unit
PO Box 3005
Arlington Heights, IL 60006-9923

I certify that:

- I have read the contents of this packet and understand what is required for each type of dependent who can be covered on my health plan.
All information submitted is true and correct as of this date.
I understand that intentionally giving incorrect information on this affidavit is considered perjury and punishable to the fullest extent of the law.
I authorize the State Health Benefits Program to verify this information.

Employee's Signature

Date

Daytime Phone Number

\*\*YOU MUST COMPLETE BOTH SIDES OF THIS FORM\*\*



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PLEASE READ THE  
INSTRUCTIONS CONTAINED  
ON THE FRONT OF THIS  
FORM

RESPONSE REQUIRED BY  
December 11, 2009

DEPENDENTS YOU HAVE COVERED AS OF AUGUST 1, 2009  
IN THE STATE HEALTH BENEFITS PROGRAM

NAME	DATE OF BIRTH	RELATIONSHIP	<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> NOT ELIGIBLE
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>