State of West Virginia Public Employee Insurance Agency
Surviving Dependent Health Benefits Enrollment Form
Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY"

SD HEALTH

Surviving Dependent

Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address / County of Residence	Home Telephone ( )
City / State / Zip	Work Telephone

Deceased Policyholder's name	Social Security Number	Date of Death
Date when you were or will be entitled to Medicare Coverage		

If you need additional space than what is provided below, please use a blank sheet of paper and attach it to this form.

Family Information

If spouse is currently insured by PEIA as a policyholder, please enter their Social Security Number ___________________________

Legal Name (Last, First, MI,Generation)	Address (if different from above)	Relationship	Sex	Birth Date	Social Security Number	Other Health Insurance (Plan Name)

Coverage

Coverage Selection (Select One) I am enrolling for:

- ☐ Single Survivor's Health Coverage
- ☐ Family Survivor's Health Coverage

Please indicate the plan in which you are enrolling by checking the box bedside the plan option you choose:

- ☐ PEIA PPB Plan A
- ☐ PEIA PPB Plan B
- ☐ The Health Plan HMO Plan A
- ☐ The Health Plan HMO Plan B
- ☐ The Health Plan PPO

Affidavits

Tobacco Affidavit: Please mark which members of the family use tobacco and sign the form. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your health and life insurance premiums. I acknowledge by signing the acceptance box below that PEIA or its agents have access to my medical records to check my tobacco use status.
Who uses tobacco:

☐ Surviving Spouse ☐ Dependent children) ☐ No Tobacco Users within the last (6) months

Acceptance

☐ I hereby accept the group coverage I have indicated above. I understand that PEIA may change the type or levels of benefits or the amount of contribution. I certify that the above information is true and correct and understand that providing false information on this form is illegal and those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations. **I understand that upon remarriage, I will no longer be eligible for Survivor coverage and it is my responsibility to report that change to PEIA.**

☐ I do not wish to participate in any PEIA Health Coverage. I decline to participate in PEIA Health Coverage.

Surviving Dependent's Signature: Date: