

# STATE OF WEST VIRGINIA EMPLOYEE ENROLLMENT FORM

July 1, 2023 - June 30, 2024

**1. INSTRUCTIONS: DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2023**

<p><b>WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?</b></p> <ul style="list-style-type: none"> <li>New participants who want to enroll for the first time.</li> <li>Employees who want to add, change or cancel any benefits.</li> <li><b>Existing benefits not indicated on this form will continue as currently enrolled.</b></li> </ul>	<p><b>HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:</b></p> <ul style="list-style-type: none"> <li><b>IMPORTANT:</b> If you want to add, change or cancel coverage, you must check the box beside the appropriate benefit in Section 3. Indicate coverage levels and any other pertinent information.</li> <li>If you select family coverage for any benefit, you must provide dependent information in Section 4.</li> </ul>	<p><b>CHANGE IN ELECTION</b></p> <ul style="list-style-type: none"> <li>Include supporting documentation.</li> <li>Must be requested within the month of and two months following your status changing event.</li> <li>List all eligible dependents you want covered.</li> </ul>
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**2.**

SSN#	E-MAIL	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> New Hire
		<input type="checkbox"/> Transfer	<input type="checkbox"/> Change in Status
LAST NAME		FIRST NAME	MI
HOME ADDRESS [STREET]		CITY	STATE ZIP HOME PHONE
BIRTH DATE	<input type="checkbox"/> MALE <input type="checkbox"/> MARRIED <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE	DATE EMPLOYED	EFFECTIVE DATE OFFICE PHONE

**3. MOUNTAINEER FLEXIBLE BENEFITS (PAID BY EMPLOYEES)**

Keep Coverage	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS		COST PER PAY PERIOD
				If you select DEPENDENT coverage for dental, vision or hearing, you must complete the dependent information in SECTION 4.		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DENTAL</b> Choose One Option: <input type="checkbox"/> Assistance <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Premier	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VISION</b> Choose One Option: <input type="checkbox"/> Exam Plus <input type="checkbox"/> Full Service	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEARING SERVICE PLAN</b>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LONG-TERM DISABILITY INCOME PLAN</b> Employee Only <input type="checkbox"/> 50% Coverage Level <input type="checkbox"/> 70% Coverage Level		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SHORT-TERM DISABILITY INCOME PLAN</b> Employee Only		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEALTH CARE FLEXIBLE SPENDING ACCOUNT</b> All Claims Must Be Submitted By <b>October 31, 2024.</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b> All Claims Must Be Submitted By <b>October 31, 2024.</b> <input type="checkbox"/> Married, Filing Separately <input type="checkbox"/> Married, Filing Jointly <input type="checkbox"/> Single, Head Of Household		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEALTH SAVINGS ACCOUNT</b> Must be enrolled in PEIA Plan C. Contribution Is Per Pay Period. You cannot enroll in a Health Care Flexible Spending Account.	Select your HSA coverage type: <input type="checkbox"/> Individual (\$3,850 maximum for PY 2024) <input type="checkbox"/> Family (\$7,300 maximum for PY 2024) <input type="checkbox"/> Over 55 Catch-up (additional maximum \$1,000)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LIMITED HEALTH CARE FSA</b> Must be enrolled in HSA.		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LEGAL (POST-TAX)</b> <input type="checkbox"/> Ultimate Advisor® Employee & Family <input type="checkbox"/> Ultimate Advisor Plus™ Employee & Family		
<b>TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD</b>						

**4. ELIGIBLE DEPENDENT INFORMATION**  
USE AN ADDITIONAL SHEET OF PAPER AS NEEDED FOR ADDITIONAL DEPENDENTS.

DEPENDENT NAME	RELATIONSHIP	MALE/ FEMALE	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED			
					DENTAL	VISION	HEARING	LEGAL
	Spouse							

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS PERMITTED BY THE PLAN AND THE IRS. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FBMC BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

**DURING OPEN ENROLLMENT, GIVE COMPLETED FORMS TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2023.**

**FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)**

**HSA EMPLOYEES MUST BE ENROLLED IN PEIA PLAN C OR ANOTHER ELIGIBLE HDHP.**

AGENCY NAME \_\_\_\_\_

4 DIGIT WORK LOCATION # \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_

NO. PAY DEDUCTIONS \_\_\_\_\_

GROSS ANNUAL SALARY \_\_\_\_\_

BENEFIT COORDINATOR SIGNATURE \_\_\_\_\_

SIGNATURE DATE \_\_\_\_\_

BENEFIT COORDINATOR PHONE# ( ) \_\_\_\_\_

BENEFIT COORDINATOR FAX# ( ) \_\_\_\_\_

ENROLLMENT FORMS SHOULD BE MAILED TO: **FBMC, PO BOX 1878, TALLAHASSEE, FL 32302-1878** DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY **MAY 21, 2023.**

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED
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