Basic Life Insurance Enrollment Form

BASIC LIFE

State of West Virginia Public Employee Insurance Agency
Basic Life Enrollment Form

Complete this form to enroll for Basic Life Insurance. Complete all sections of the form except "AGENCY"

Employee

Legal Name (Last) (First) (M I) (Generation: Jr., Sr., etc.)			Social Security Number
Mailing Address County of Residence			Home Telephone ( )
City	State	Zip	Work Telephone ( )
Physical Address			Sex (Circle one) M F
City State Zip			Date of Birth (mm/dd/yy)

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

Beneficiary(ies)

Please delegate the beneficiary(ies) of this basic term life insurance policy in the space provided below. The name of the beneficiary should be fully spelled out and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. K. Doe". If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries that survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Beneficiary Legal Name (Last, First, MI, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%

Coverage

Decreasing Term Benefit For Active Employees for:

Employee under age 65	$10,000
Employee Age 65 but under 70	$6,500
Employee Age 70 and over	$5,000

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 use tobacco, you will receive the discount on your health and Opt/Dep 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: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ No Tobacco Users within the last (6) months

Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? ☐ Yes ☐ No

Acceptance

☐ I hereby accept the Basic Life Insurance. 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 do not wish to participate in PEIA Basic Life Insurance. I decline to participate in Basic Life Insurance.

Employee's Signature: Date:

Agency

Agency Name	Account Number	Date of Employment	
Hours worked Weekly	Effective Date of Coverage	Coverage Code	Index Code

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature : Date:

May 2017

Basic Life Insurance Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit agency account number as it appears on your billing.

Date of Employment: Date Employee was hired or the date he or she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms and returns it to you to elect the coverage), if it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application; PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. Minnesota Life will contact you when the medical underwriting decision has been made. Please see the Life section of the BCRM for further details. The employee must be actively at work for coverage to begin. If the employee is not actively at work due to illness or injury on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Coverage Code: Mark with code LB01 for basic life.

Index Code: Choose the code from the appropriate charts on Page 2 and 3 that reflects the employee's annual salary.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Health Benefits Enrollment Form

HEALTH

State of West Virginia Public Employee Insurance Agency
Health Benefits Enrollment Form

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY"

Employee

Legal Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address		County of Residence		Home Telephone ( )
City	State	Zip		Work Telephone ( )
Physical Address				Sex (Circle one) M F
City	State	Zip		Date of Birth (mm/dd/yy)

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

Dependent Information

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:

- ☐ Employee Only
- ☐ Employee/Child(ren) Only
- ☐ Family

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
- ☐ PEIA PPB Plan C
- ☐ PEIA PPB Plan D
- ☐ 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: ☐ Policyholder ☐ Dependent (spouse and/or 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 of 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 do not wish to participate in any PEIA Health Coverage. I decline to participate in PEIA Health Coverage.

Employee's Signature: Date:

Agency

Agency Name	Account Number	Date of Employment	
Hours worked Weekly	Effective Date of Coverage	Index Code	Coverage Code

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature: Date:

January 2019

Health Benefits Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Date of Employment: Date Employee was hired or the date he/ she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms to elect the coverage). Remember that the employee must be actively at work for coverage to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work. If paperwork is not sent in until the month after employment began, coverage may not begin until the first of the following month and there may be a lapse in coverage.

Index Code: Choose the code from the appropriate chart below to reflect the employee's annual salary

Non-State Agencies Do Not fill in an Index Code.

For State Agencies, Colleges, Universities and County Boards of Education For the PEIA PPB Plan A and ALL managed care coverages		
	Salary	
Index Code	From	To
01	$ 0	$ 25,400
02	$ 25,401	$ 35,400
03	$ 35,401	$ 41,400
04	$ 41,401	$ 47,400
05	$ 47,001	$ 55,400
06	$ 55,401	$ 67,900
07	$ 67,901	$ 80,400
08	$ 80,401	$105,400
09	$105,401	$130,400
10	$130,401	and over

Coverage Code: Please use one of the codes below to indicate which plan the policyholder chose:

HI01	PEIA PPB Plan A
HI02	PEIA PPB Plan B
HI03	PEIA PPB Plan C
HI04	PEIA PPB Plan D
HMHP - A	The Health Plan HMO Plan A
HMHP - B	The Health Plan HMO Plan B
HMHP – C	The Health Plan HMO Plan C

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Policyholder Only
F = Policyholder, Spouse and Children
C = Policyholder and Children Only
S = Policyholder and Spouse Only (generates same premium as F)

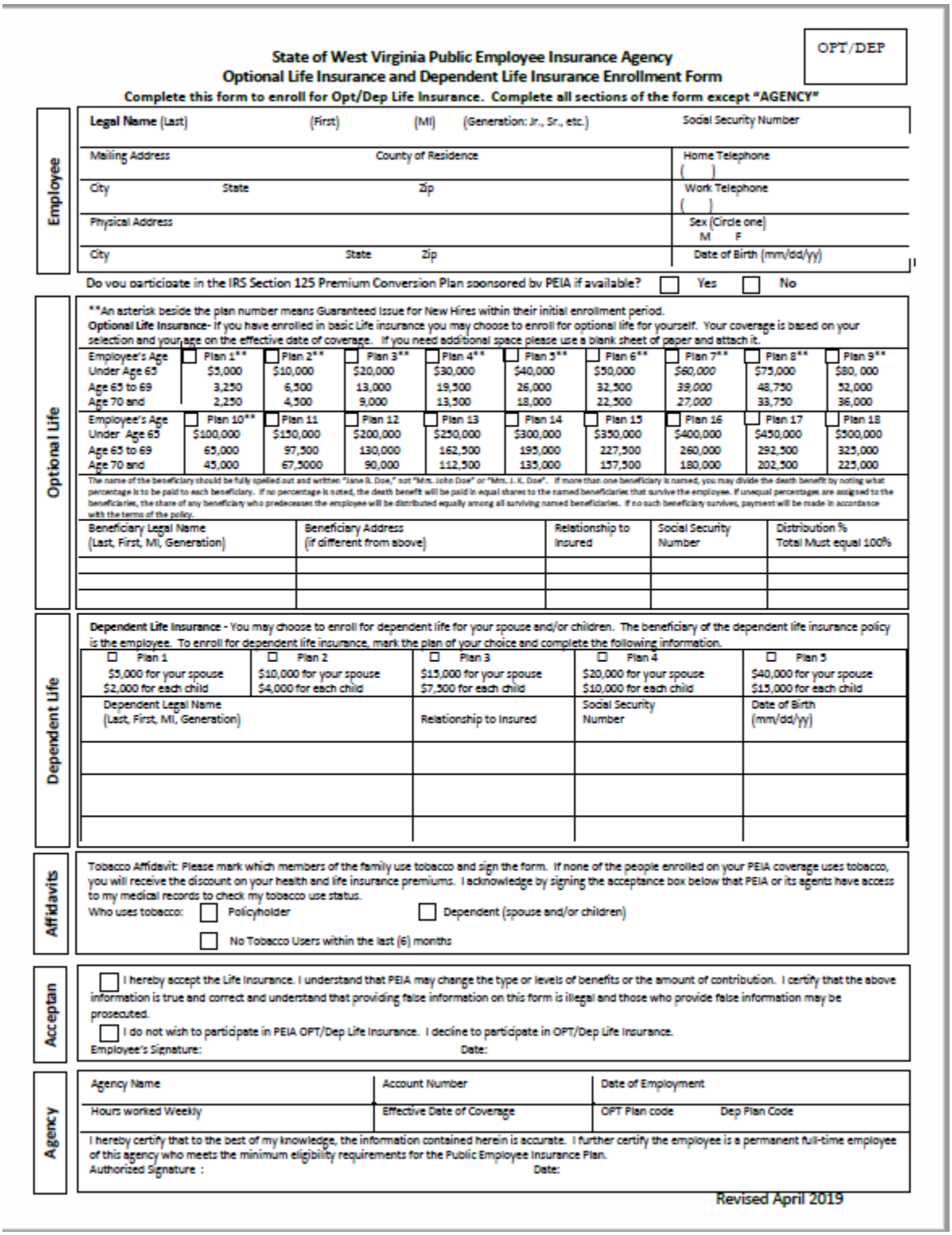
Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. If the addition of health coverage creates as ESPS situation, PEIA needs to be aware of the IDX change if applicable so that it may be made at time of entry into the PEIA system. PEIA does not have access to salaries.

A completed Coverage code could look like this: **HI01 – P,** or like this: **HMHP-B-F.**

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Optional and Dependent Life Insurance Enrollment Form (OPT)



OPT/DEP

State of West Virginia Public Employee Insurance Agency
Optional Life Insurance and Dependent Life Insurance Enrollment Form
Complete this form to enroll for Opt/Dep Life Insurance. Complete all sections of the form except "AGENCY"

Employee

Legal Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address	County of Residence			Home Telephone ( )
City	State	Zip		Work Telephone ( )
Physical Address				Sex (Circle one) M F
City	State	Zip		Date of Birth (mm/dd/yy)

Do you participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA if available? ☐ Yes ☐ No

Optional Life

**An asterisk beside the plan number means Guaranteed Issue for New Hires within their initial enrollment period.
Optional Life Insurance- If you have enrolled in basic Life insurance you may choose to enroll for optional life for yourself. Your coverage is based on your selection and your age on the effective date of coverage. If you need additional space please use a blank sheet of paper and attach it.

Employee's Age	☐ Plan 1**	☐ Plan 2**	☐ Plan 3**	☐ Plan 4**	☐ Plan 5**	☐ Plan 6**	☐ Plan 7**	☐ Plan 8**	☐ Plan 9**
Under Age 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$75,000	$80, 000
Age 65 to 69	3,250	6,500	13,000	19,500	26,000	32,500	39,000	48,750	52,000
Age 70 and	2,250	4,500	9,000	13,500	18,000	22,500	27,000	33,750	36,000

Employee's Age	☐ Plan 10**	☐ Plan 11	☐ Plan 12	☐ Plan 13	☐ Plan 14	☐ Plan 15	☐ Plan 16	☐ Plan 17	☐ Plan 18
Under Age 65	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
Age 65 to 69	65,000	97,500	130,000	162,500	195,000	227,500	260,000	292,500	325,000
Age 70 and	45,000	67,5000	90,000	112,500	135,000	157,500	180,000	202,500	225,000

The name of the beneficiary should be fully spelled out and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. K. Doe". If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries that survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Beneficiary Legal Name (Last, First, MI, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%

Dependent Life

Dependent Life Insurance - You may choose to enroll for dependent life for your spouse and/or children. The beneficiary of the dependent life insurance policy is the employee. To enroll for dependent life insurance, mark the plan of your choice and complete the following information.

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4	☐ Plan 5
$5,000 for your spouse $2,000 for each child	$10,000 for your spouse $4,000 for each child	$15,000 for your spouse $7,500 for each child	$20,000 for your spouse $10,000 for each child	$40,000 for your spouse $15,000 for each child

Dependent Legal Name (Last, First, MI, Generation)	Relationship to Insured	Social Security Number	Date of Birth (mm/dd/yy)

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: ☐ Policyholder ☐ Dependent (spouse and/or children)

☐ No Tobacco Users within the last (6) months

Acceptan

☐ I hereby accept the Life Insurance. 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 do not wish to participate in PEIA OPT/Dep Life Insurance. I decline to participate in OPT/Dep Life Insurance.

Employee's Signature: Date:

Agency

Agency Name	Account Number	Date of Employment	
Hours worked Weekly	Effective Date of Coverage	OPT Plan code	Dep Plan Code

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature : Date:

Revised April 2019

Optional and Dependent Life Insurance Enrollment Form (OPT)

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit agency account number as it appears on your billing.

Date of Employment: Date of full-time employment for the employee with your agency.

Hours Worked Weekly: Number of hours the employee works each week.

Effective Date of Coverage: When completing the form, enter the first day of the month following date of enrollment, (the date the employee signs the form and returns it to you to elect the coverage) if it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application provided by the life insurance carrier. PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. Minnesota Life will contact you when the medical underwriting decision has been made. Please see the Life section of the BCRM for further details. The employee must be actively at work for coverage (or an increase in the amount of coverage) to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

OPT Plan: Use the option code below based on the plan chosen by the employee.

Active Employee Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	300
Plan IV	400
Plan V	500
Plan VI	600
Plan VII	650
Plan VIII	700
Plan IX	750
Plan X	800
Plan XI	900
Plan XII	950
Plan XIII	951
Plan XIV	952
Plan XV	953
Plan XVI	954
Plan XVII	955
Plan XVIII	956

If an employee chooses more than $100,000 of coverage, he or she will be required to provide Evidence of Insurability. Please see the Life section of the BCRM for further details.

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400
5	500

Please note that if documentation is required for a dependent and cannot be submitted with the Optional and Dependent Life Insurance Enrollment form, the form on page 15 should accompany submission of the documentation to PEIA.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Basic and/or Optional Life Insurance

Change of Beneficiary Form

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries who survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, the payment will be made in accordance with the terms of the policy. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person CANNOT be named as a primary and a contingent beneficiary.

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) – The person or persons named will receive the benefit					
Legal Full Name (Last, First, MI, Generation)	**Date of Birth**	**Address and Phone Number**	**Social Security Number**	**Relationship**	**Share % (must total 100%)**
Smith, Jane A.	01-01-1971	123 Main Street, Anywhere, WV, 12345; 304-555-1234	XXX-XX-XXXX	Daughter	100%
					Total = 100%
CONTINGENT BENEFICIARY(IES) – If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Legal Full Name (Last, First, MI, Generation)	**Date of Birth**	**Address and Phone Number**	**Social Security Number**	**Relationship**	**Share % (must total 100%)**
Brown, Nancy B.	02-02-1951	456 Main Street, Anywhere, WV, 12345; 304-555-4567	XXX-XX-XXXX	Sister	100%
					Total = 100%

Example 2: If more than one primary beneficiary is to receive the benefit first, followed by the contingent beneficiary(ies) if all the primary beneficiaries are deceased.

PRIMARY BENEFICIARY(IES) – The person or persons named will receive the benefit					
Legal Full Name (Last, First, MI, Generation)	**Date of Birth**	**Address and Phone Number**	**Social Security Number**	**Relationship**	**Share % (must total 100%)**
Smith, Jane A.	01-01-1971	123 Main Street, Anywhere, WV, 12345; 304-555-1234	XXX-XX-XXXX	Daughter	40%
Smith, John J., Sr.	03-03-1952	123 Main Street, Anywhere, WV, 12345; 304-555-1234	XXX-XX-XXXX	Husband	40%
Jones, Mary C.	04-04-1965	22 Oak Street, Anywhere, WV, 12345; 304-555-2222	XXX-XX-XXXX	Friend	20%
					Total = 100%
CONTINGENT BENEFICIARY(IES) – If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Legal Full Name (Last, First, MI, Generation)	**Date of Birth**	**Address and Phone Number**	**Social Security Number**	**Relationship**	**Share % (must total 100%)**
Brown, Nancy B.	02-02-1951	456 Main Street, Anywhere, WV, 12345; 304-555-4567	XXX-XX-XXXX	Sister	50%
Johnson, Jack E.	05-05-1958	5 Elm Street, Anywhere, WV, 12345; 304-555-5555	XXX-XX-XXXX	Brother	50%
					Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) – The person or persons named will receive the benefit					
Legal Full Name (Last, First, MI, Generation)	**Date of Birth**	**Address and Phone Number**	**Social Security Number**	**Relationship**	**Share % (must total 100%)**
Smith, Jane A. – Trustee, her successors or successor in trust under the Jane A. Smith Revocable Trust Agreement. Executed by the insured on June 1, 2008.			N/A	Trust	100%
					Total = 100%

Visit securian.com/beneficiary-info for more information about naming life insurance beneficiaries.

CIB

Change in Beneficiary Form

State of West Virginia Public Employee Insurance Agency

601 57th St., SE, Suite 2 • Charleston, WV 25304-2345

Full Legal Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address		County of Residence		Home Telephone ( )
City	State	Zip		Work Telephone ( )
Physical Address				Gender (Circle One) M F
City	State	Zip		Date of Birth (mm/dd/yy)

INSTRUCTIONS: Clearly print or type the information below, then sign and date the completed form. Return to the address listed above or fax to 1(877) 233-4295 or 1(304) 558-2470.

EMPLOYEE BASIC LIFE BENEFICIARY DESIGNATIONS

PRIMARY BENEFICIARY(IES) – The person or persons named will receive the benefit

Legal Full Name (Last, First, MI, Generation)	Date of Birth	Address and Phone Number	Social Security Number	Relationship *Spouse/Child/Other*	Share % (must total 100%)

CONTINGENT BENEFICIARY(IES) – If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Legal Full Name (Last, First, MI, Generation)	Date of Birth	Address and Phone Number	Social Security Number	Relationship *Spouse/Child/Other*	Share % (must total 100%)

OPTIONAL LIFE BENEFICIARY DESIGNATIONS

☐ *Same Beneficiaries and Shares as Basic Life Designations*

PRIMARY BENEFICIARY(IES) – The person or persons named will receive the benefit

Legal Full Name (Last, First, MI, Generation)	Date of Birth	Address and Phone Number	Social Security Number	Relationship *Spouse/Child/Other*	Share % (must total 100%)

CONTINGENT BENEFICIARY(IES) – If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Legal Full Name (Last, First, MI, Generation)	Date of Birth	Address and Phone Number	Social Security Number	Relationship *Spouse/Child/Other*	Share % (must total 100%)

SIGNATURES REQUIRED	
Insured's signature X	Date
Witness's signature X	Date

This form is not specifically for use by Benefit Coordinators and does not require the Benefit Coordinator's signature. We are including it in this book for your convenience and reference.

Waiver of Premium Claim

(Disability Waiver of Premium)

If you have an employee applying for a disability waiver of premium, the Employer's Statement must be completed by you.

Waiver of Premium Claim
Employer's Statement

MInnesota LIfe Insurance Company, a Securian Financial Group affiliate • Group Division Claims
Charleston Branch Office • PO Box 3742 • Charleston, WV 25337-3742 • Toll free 1-800-203-9515

MINNESOTA LIFE

Type of Claim: ☐ **Active Employee** ☐ **Retiree**

Policyholder's name	Policy number	Account number	Coverage code
PEIA	**33227**		

Insured employee's name (Last, First, Middle Initial)	Employee ID	Gender
		☐ Male ☐ Female

Street address

Date of birth (Month, Day, Year)	Date employed (Month, Day, Year)	Social Security number

Job title	Date last worked

Status on employment date ☐ Full time ☐ Part time If part-time, average hours per week. _____

Amount of Employee's Insurance	Effective Date of Coverage
Basic $ _____	_____

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

Name of employer	Employer's telephone number

Employer's address

Authorized signature	Date
X	

F53421-PEIA 6-2006 PEIA Waiver Claim Packet 6-2006

Type of Claim: Check the status that applies to the employee.

Account Number: Enter the agency account number from your PEIA monthly billing.

Coverage Code: Mark with code **LB0**1 for basic life. The premium can only be waived for the basic life insurance. Premiums must be paid by the policyholder for any optional coverage to keep it in force.

Insured employee's name: Enter the policyholder's full name.

Employee ID: Enter the policyholder's social security number.

Gender: Indicate the gender of the policyholder.

Street Address: Enter the policyholder's home address.

Date of Birth: Enter the policyholder's date of birth.

Date Employed: Date of full-time employment for the employee with your agency.

Social Security Number: Enter the policyholder's social security number.

Job Title: Enter the job title of the policyholder.

Date last worked: Indicate the last date that the employee was actively at work on a full-time basis.

Status on employment date: Indicate whether the employee was full-time or part time.

Amount of Employee's insurance: Fill in the amount of basic life insurance on the employee and the effective date of coverage.

Employer Certification:

Name of Employer: Your agency name as it appears on your PEIA monthly billing.

Telephone Number: Enter your work phone number.

Address: Enter your agency's mailing address

Authorized Signature: Your signature as the Benefit Coordinator

Date: The date you signed the form. Forms should be signed immediately upon receipt.

When the form is completed, submit it to WVPEIA, State Capitol Complex, Bldg. 5, Rm. 1001, 1900 Kanawha Blvd. E, Charleston, WV 25305-0710.

Change - In - Status Form

State of West Virginia Public Employee Insurance Agency
Change In Status Form

CIS

Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

Employee

Full Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address County of Residence	Home Telephone ( )
City State Zip	Work Telephone ( )
Physical Address	Sex (Circle one) M F
City State Zip	Date of Birth (mm/dd/yy)

Change in Status Reason

Please indicate the status change you are making:

☐ Name Change: ☐ Policyholder ☐ Dependent (Last)_____ (First)_____ (MI)____

☐ Add Dependents to: ☐ Health Dependent/Optional Life ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5

Complete Dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.

☐ Remove Dependents from: ☐ Health Dependent Optional Life: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5

☐ Change in Health Coverage from Plan_____to Plan_____

☐ Add Health Coverage ☐ PEIA Plan A ☐ PEIA Plan B ☐ PEIA Plan C ☐ PEIA Plan D
☐ The Health Plan HMO Plan A ☐ The Health Plan HMO Plan B ☐ The Health Plan PPO Plan C

☐ Drop Health Coverage. Keep Life Insurance Only. This terminates Health Coverage for Policyholder and all dependents.

☐ Tobacco Status Change

☐ Other, Please Specify_____

For each Qualifying event PEIA requires documentation. To add a dependent, PEIA requires documentation to substantiate legal dependency. Please see your Benefit Coordinator for questions about necessary documentation. The member's name, social security number and agency of employment must be written across the top of all documents submitted to PEIA.

Dependent 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)

January 2019

State of West Virginia Public Employee Insurance Agency
Change In Status Form

CIS

Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

Change in Status Reason

☐ Marriage	☐ Death of a dependent	☐ Open Enrollment
☐ Divorce	☐ Birth of a Child	☐ Affordable Care Act
☐ Unpaid Leave of Absence by Employee, Spouse or Dependent	☐ Significant Change in Health Coverage	☐ Change from full-time to part-time or vice versa of the employee, spouse or dependent
☐ Adoption	☐ Beginning or end of a dependent's employment	☐ Other (Please Specify):

COBRA

Under federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by HealthSmart Solutions, who administers COBRA for PEIA. You will have a limited amount of time to elcect continuation of coverage.
COBRA premiums include both the employer and employee share of the premium, as well as an adminstrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact HealthSmart at 1-888-440-7342.
If the dependent's address is different than the policyholder's address, please provide the dependent's mailing address below:
Dependent Name: _____
Street Name: _____
City, State and Zip: _____

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 use tobacco, you will receive the discount on your health and Opt/Dep 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: ☐ Policyholder ☐ Dependent (spouse and/or 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.

Employee's Signature: Date:

Agency

Agency Name	Account Number
Effective Date of Status Change	Index Code

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature: Date:

January 2019

Change - In - Status Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Effective Date of This Status Change: Typically, this date is the 1st day of the following month the employee has signed to elect the change. For example, if the Change in Status is dated Jan 28, 2017 by the employee, the effective date would be February 1, 2017.

In the case of a newborn or adopted child, the effective date may be retroactive. For **newborns** added within the month of birth and the two following calendar months effective date of coverage is the date of the child's birth. For **adopted children** if added within the month of adoption or the following two calendar months, the effective date of coverage is retroactive to the date the child was placed in the home or the date the policyholder became financially responsible for the adopted child.

Index Code: Choose the code from the appropriate chart below to reflect the employee's annual salary.

For State Agencies, Colleges, Universities and County Boards of Education For the PEIA PPB Plans A & B and ALL managed care coverages		
	Salary	
Index Code	From	To
01	$ 0	$ 20,000
02	$ 20,001	$ 30,000
03	$ 30,001	$ 36,000
04	$ 36,001	$ 42,000
05	$ 42,001	$ 50,000
06	$ 50,001	$ 62,500
07	$ 62,501	$ 75,000
08	$ 75,001	$100,000
09	$100,001	$125,000
10	$125,001	and over
04	Legislature	

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Eligibility Documentation Memo

Jim Justice
Governor

Ted Cheatham
Director

WV Toll free: 1-888-680-7342 • Phone: 1-304-558-7850 • Fax: 1-304-558-2470 • Internet: www.wvpeia.com

To: PEIA Eligibility Documentation Unit

From: _____ Date: _____
(policyholder's name)

Re: Unique ID number [ ] OR

Last four digits of SSN [redacted]-[redacted]-[ ]

Please mark who you're adding to coverage and the documentation attached.

	Status Change Event	Documentation Required
	Divorce	Provide a copy of the divorce decree showing that the divorce is final.
	Marriage	Copy of valid marriage license or certificate
	Birth of Child	Copy of child's birth certificate
	Adoption	Copy of adoption papers
	Adding coverage for a stepchild who resides with the policyholder	Copy of child's birth certificate.
	Adding coverage for any other child who resides with the policyholder	Court-ordered guardianship papers.
	Open Enrollment under spouse's employer's benefit plan	A copy of printed material showing open enrollment dates and the employer's name.
	Death of spouse or dependent	A copy of the death certificate.
	Beginning of spouse's employment	A letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered.
	End of spouse's employment	A letter from the spouse's employer stating the termination or retirement date, what coverage was lost, and dependents that were covered.
	Unpaid leave of absence by employee or spouse	A letter from your or your spouse's personnel office stating the date that you or your spouse went on unpaid leave or returned from unpaid leave.
	Significant Change in Health Coverage Attributable to Spouse's or Dependent's Employment	A letter from the spouse's insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered.
	Change from full-time to part-time employment or vice versa for employee or spouse	A letter from your or your spouse's employer stating the previous hours worked and the new hours worked and the effective date of the change.
I understand that PEIA cannot process my enrollment or change in enrollment for me or my dependents until these documents have been received.		

Please send this cover sheet with your document(s) to the address below.

601 57th Street, SE • Suite 2 • Charleston, WV 25304-2345
An equal opportunity employer.

Remember that all changes require documentation, and no changes can be made outside Open Enrollment without a qualifying event. If you cannot submit the documentation with the Change in Status form, the form on this should accompany submission of documentation to PEIA.

Change - In - Address Form

State of West Virginia Public Employee Insurance Agency
Change In Address Form

CIA

Complete this form to Change the Address for you or your dependents.
Complete all sections of the form except "AGENCY"

Please Note: Changing your address with PEIA **does not update the information with Mountaineer Flexible Benefits.** You must also complete a Demographic Change form and send it to FBMC to update your information in their system.

Employee

Full Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
Old Mailing Address County of Residence	Home Telephone ( )
City State Zip	Work Telephone ( )
Physical Address	Sex (Circle one) M F
City State Zip	Date of Birth (mm/dd/yy)

New Address

New Mailing Address		County of Residence
City	State	Zip
Physical Address		
City	State	Zip

Dependent

Legal Name (Last, First, MI,Generation)	New Address (if different from above)

Signature

Agency Name

I hereby certify that to the best of my knowledge, the information contained herein is accurate and that providing false information on this form is illegal and those who provide false information may be prosecuted.

Policyholder's Signature: Date:

August 2017

This form is not specifically for use by Benefit Coordinators and does not require the Benefit Coordinator's signature. We are including it in this book for your convenience and reference.

Policyholder Termination of Coverage Form

State of West Virginia Public Employee Insurance Agency
Policyholder Termination of Coverage Form
Complete this form to terminate health/life coverage. Complete all sections of the form except "AGENCY"

TERM

Employee

Full Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address County of Residence	Home Telephone ( )
City State Zip	Work Telephone ( )
Physical Address	Sex (Circle one) M F
City State Zip	Date of Birth (mm/dd/yy)

If your spouse is currently insured by PEIA as a policyholder, please provide the Social Security Number _____

Termination Reason

***Participants cannot voluntarily terminate a benefit without a qualifying event. If you are requesting this action outside of open enrollment period, please state the qualifying event and attach documentation to support the event. Please refer to the Summary Plan Description for further details and a list of qualifying events.

- ☐ Resignation (B.C: If transferring to another PEIA insured agency, please use the online transfer function in Manage My Benefits)
- ☐ Terminated for Misconduct (If an Administrative appeal is being instituted, please complete the *Administrative Appeal* section of this form)
- ☐ Terminated involuntarily or by reduction in work force.
  I ☐ do ☐ do not accept the (3) additional months of extended benefits.
- ☐ Voluntarily cancel all coverage. Re-enrollment restrictions may apply***
  (To cancel health insurance only, use a Change in Status form)
- ☐ Retirement
- ☐ Cancellation of Employee Basic Life Insurance***
- ☐ Cancellation of Employee Optional Life Insurance***
- ☐ Cancellation of Dependent Optional Life Insurance***
- ☐ Deceased (Please enter the date of death) _____
- ☐ Surviving Dependent Remarriage (Please enter the date of Marriage) _____
- ☐ Termination (If policyholder is unavailable for signature, Form must be signed the BC and by another staff member of the agency)
- ☐ Affordable Care Act
- ☐ Other (Please explain)_____

Required Policyholder Signature: Date:

Administrative Appeal

In the case of a termination for misconduct, you may have the right to an administrative appeal. If the administrative appeal is to be instituted, with your employer's approval, you may continue to pay your "employee's share" of the monthly premium. If you lose the appeal, and have elected to continue your coverage for these additional months, you will be required to reimburse the total premium for the months during which you have continued your coverage.
Please mark your choice:

- ☐ I elect to continue coverage during the administrative appeal, realizing fully that if my appeal is lost, I am responsible for reimbursing the entire premium to the agency or to the State of West Virginia.
- ☐ I decline to continue coverage during the administrative appeal.

Policyholder Signature: Date:

COBRA

Under federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by UMR, PEIA's COBRA administrator. You will have a limited amount of time to elect continuation of coverage. COBRA premiums include bothe the employer and employee share of the premium, as well as an administrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact UMR at 1-888-440-7342.

Agency

Agency Name	Account Number	Current Coverage Code
Date off Payroll	Effective Date of Termination	

I hereby certify that to the best of my knowledge, the information contained herein is accurate.

Benefit Coordinator Signature:_____ Date:_____

Agency Authorized Signature:_____ Title:_____

Date Signed: _____

March 2019

Policyholder Termination of Coverage Form

Account Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice

Current Coverage Code: Indicate the Code of Coverage under which the employee was last covered.

HI01 PEIA PPB Plan A
HI02 PEIA PPB Plan B
HI03 PEIA PPB Plan C
H104 PEIA PPB Plan D
HMHP - A The Health Plan HMO Plan A
HMHP - B The Health Plan HMO Plan B
LB01 Life Insurance Only

Date Off Payroll: The last day the employee is on payroll.

Effective Date of Termination: This date should be the last day of the calendar month in which the employee's coverage ends. If an employee went off payroll January 1st, the effective date of termination would be January 31st. In the event an employee's last paycheck would not cover the PEIA health premium, and the employee chooses not to pay the premium, please indicate the last month for which the employee paid premiums. In the case where the dates are not within the same month, please provide details in the "other please explain" section.

Authorized Signature: Your signature as the Benefit Coordinator.

Agency Authorized Signature: If the Policyholder is unavailable to sign the Termaination form, PEIA requires a second authorized signature and title to confirm termination of the employee.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder

Retirement Health Benefits and Basic Life Enrollment Form

State of West Virginia Public Employee Insurance Agency
Retiree Health and Life Insurance Enrollment Form
Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Retiree
BL/Health

Retirement Health Benefits and Basic Life Insurance Enrollment Form Instructions

Retiree: Complete all demographic information. Use your full **LEGAL** name. The 'Generation' area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III etc.

The Medicare ID Number can be found on your red, white and blue Medicare card. The number is required for continued coverage when you reach Medicare age. If you are not yet eligible for Medicare, please send PEIA a copy of your Medicare card when you enroll for Medicare coverage. Your premium decreases when you are retired and have Medicare.

Please provide the date when you were or will become eligible for Medicare. **When you become eligible for Medicare it is important that you enroll for both Medicare parts A and B.** Please see your Summary Plan Description for more information.

PEIA needs information about your last employer prior to retirement and the last day worked (or will work) for that employer.

Dependent Information: Fill in any dependents that are to be covered under your health insurance plan. Please complete each box and if they are Medicare eligible we will need a copy of their Medicare card. Please see the documentation chart in the Summary Plan Description to know what documentation is needed for proof of legal dependency for any dependents you may be adding.

Basic Life Beneficiary(s): You may enroll in a basic decreasing term life insurance policy for yourself. If you do so, please designate your beneficiary (s) in this section. Life insurance proceeds will be distributed equally among all designated beneficiaries unless you specify otherwise on this form. If unequal percentages are assigned to the beneficiary, the share of any beneficiary who predeceases the policyholder will be distributed equally among all surviving named beneficiaries. If no beneficiary survives the policyholder, payment will be made in accordance with the terms of the policy. The name of the beneficiary should be written "Jane B. Doe", not "Mrs. Jon Doe" or "Mrs. J. A. Doe".

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are to continue your health care coverage into retirement, you must remain in the health care plan you were in as an active employee through the end of the plan year (June 30), unless you were in PEIA PPB Plans C or D, which are not offered to retirees, or you were enrolled in a managed care plan and will be Medicare eligible when you retire. Please be sure to mark the plan you want. For life insurance, on this form you can continue your Basic Life insurance. If you wish to continue Optional and/or dependent coverage, you must complete the Retiree Optional Life Insurance form.

State of West Virginia Public Employee Insurance Agency
Retiree Health and Life Insurance Enrollment Form
Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Retiree
BL/Health

Earned Extended Benefits: If you have sick and/or annual leave credits, or faculty teaching credits, you must specify how you want to use those credits. You may use sick/annual leave credits to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. For details, please see your Summary Plan Description. If you were hired after July 1, 2001 (or July 1, 2009, for faculty), you are not eligible for this benefit.

Affidavit: PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discount.

Acceptance: When you have made your selections on this form, you must sign and date the "Acceptance" box and sign and date the bottom of the acceptance box. If you do not wish to enroll for health or life insurance coverage as a retiree, you must mark the appropriate "Declination" box and sign and date below it.

What next: When your form is completed to this point, please return it to the Benefit Coordinator at your place of employment. Your Benefit Coordinator in your HR department will complete the agency portion of the form and submit it for processing.

Retiree
BL/Health

State of West Virginia Public Employee Insurance Agency
Retiree Health and Life Insurance Enrollment Form

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Please read and follow the instructions included with this form when completing. Use this form to enroll for health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. This is a two-page form. You must submit both pages for your enrollment to be valid. Incomplete forms will be returned and may delay your enrollment. Complete all sections of the form except the last "Agency" portion. Return the completed forms to your HR department.

Retiree Information

Legal Name (Last)	(First)	(MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address		County of Residence	Medicare ID Number
City	State	Zip	Home Telephone ( )
Physical Address			Sex (Circle one) M F
City	State	Zip	Date of Birth (mm/dd/yy)
Provide the date when you were or will be Medicare Eligible: Please also Provide a copy of your Medicare ID card now or when you are Medicare eligible.			Personal Email Address
Provide the name of your last employer and your last day worked:			

Dependent Information

Complete the following information **ONLY for dependents to be covered under your plan.**

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

Basic Life Beneficiary(s)

Basic Life Insurance Beneficiary(s)

Please designate the beneficiary(s) of your Basic Life insurance coverage below. The name of the beneficiary must be the full LEGAL name spelled out, and written Jane B. Doe and not Mrs. John Doe or J. A. Doe.

Legal Name (Last, First, MI,Generation)	Address (if different from above)	Relationship	Social Security Number	Distribution %

This form is continued on page 2. You must complete and return both pages of the form for it to be valid.

PLEASE Continue.

Retiree
BL/Health

State of West Virginia Public Employee Insurance Agency
Retiree Health and Life Insurance Enrollment Form

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Please read and follow the instructions included with this form when completing. Use this form to enroll for health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. This is a two-page form. You must submit both pages for your enrollment to be valid. Incomplete forms will be returned and may delay your enrollment. Complete all sections of the form except the last "Agency" portion. Return the completed forms to your HR department.

Coverage

Coverage Selection (Select One) I am enrolling for:

- ☐ Policyholder Only Health and Life
  Mark plan choice below
- ☐ Family Health and Life
  Mark plan choice below
- ☐ Life Insurance Only (No Health Benefits)
- ☐ Life Insurance Only (Health Benefits under spouse's PEIA plan)
- ☐ Health Insurance Only (No Life Insurance Benefits) Mark plan choice below

Earned Extended Benefits
Sick and/or Annual leave and Faculty Credits
I choose to use my credits to:

- ☐ Extend my employer-paid insurance coverage. Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining credits.
- ☐ Increase my annuity amount.
  (Complete proper forms from CPRB)

Please be aware that if you submit conflicting documents regarding the use of your leave credits, the document you file with the CPRB will take precedence.

Plan

☐ PEIA PPB Plan A/Special Medicare Plan ☐ PEIA PPB Plan B
☐ Health Plan HMO Plan A ☐ Health Plan HMO Plan B ☐ Health Plan POS Plan C

Health Plan HMO and POS Plans are NOT available to Medicare Retirees/Dependents. Medicare Retirees choosing to move immediately to Humana must contact PEIA for a Transfer Form.

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: ☐ Policyholder ☐ Dependent (spouse and/or 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 of 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 do not wish to participate in **ANY** PEIA Health Coverage or Basic Life Coverage. I decline to participate in **ANY** PEIA Coverage at this time.

Signature: Date:

Agency

Agency Name	Agency Account Number	Hire Date
Last date of active Employment	Effective Date of Retirement	Effective date of Retiree Insurance Coverage

Number of **Days** of accrued sick and annual leave for which the employee was not paid when employment ceased.

Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 moth family coverage)
Partial months are not allowed.

Total WV State Government credited years of service:

Higher Education Faculty Only: Total years of extended coverage in months:
3 and 1/3 years = 1 year of single coverage; 5 years' service = 1 year family coverage

Member Retirement from: ☐ TIAA-CREF ☐ TRS ☐ TDC ☐ PERS ☐ TROOPERS ☐ OTHER: _____

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee meets the minimum eligibility requirements for the Public Employee Insurance Plan.
Authorized Signature: Date:

November 2019 4

Retirement Health Benefits and Basic Life Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Agency Account Number: Your 9-digit number found on the monthly billing invoice

Hire Date: Enter the date in month, day and year policyholder was hired.

Last date of Active Employment: Date employee was last actively on payroll

Effective Date of Retirement: Date the employee retires

Effective Date of Retiree Insurance Coverage: First day of the month following the date of retirement

Number of days accrued, sick and annual: Enter the total number of days to be used towards payment of premiums.

Number of Months earned extended coverage: Enter the total number of months earned for coverage of premiums. 2 days = 1 month of single coverage and 3 days = 1 month of family coverage. Partial months are not allowed.

WV State Credited years of Service: Enter the correct number of years without lapse in service.

Higher Ed years of extended coverage: Enter the correct number of months of extended coverage. 3 and 1/3 years = 1 year of single coverage and 5 years of service = 1 year of family coverage

Member Retirement from: Mark the correct box if any apply.

Authorized Signature: Your signature as the Benefit Coordinator

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Retirement Optional/Dependent Life Enrollment Form

State of West Virginia Public Employee Insurance Agency
Retiree Optional Life Insurance and Dependent Life Insurance Enrollment Form
Complete this form to enroll for Opt/Dep Life Insurance. Complete all sections of the form except "AGENCY"

RET OPT/DEP

Employee

Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address / County of Residence	Home Telephone ( )
City / State / Zip	
Physical Address	Sex (Circle one) M F
City / State / Zip	Date of Birth (mm/dd/yy)

You Must be enrolled with BASIC LIFE to enroll in Optional and/or Dependent Life. If you have not enrolled for Basic Life, please fill out a Retiree Basic Life and Health Enrollment Form to enroll in Basic Life prior to submitting this form.

Optional Life

Optional Life Insurance- If you have enrolled in basic Life insurance you may choose to enroll for optional life for yourself. Your coverage is based on your selection and your age on the effective date of coverage. If you need additional space please use a blank sheet of paper and attach it.

Employee's Age	☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4	☐ Plan 5
Under Age 65	$5,000	$10,000	$15,000	$20,000	$30,000
Age 65 to 69	3,250	6,500	9,750	13,000	19,500
Age 70 and above	2,500	5,000	7,500	10,000	15,000
Employee's Age	**☐ Plan 6**	**☐ Plan 7**	**☐ Plan 8**	**☐ Plan 9**	**☐ Plan 10**
Under Age 65	$40,000	*$50,000*	$75,000	$100, 000	$150,000
Age 65 to 69	26,000	*32,500*	48,750	65,000	97,500
Age 70 and above	20,000	*25,000*	37,500	50,000	75,000

The name of the beneficiary should be fully spelled out and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. K. Doe". If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries that survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Beneficiary Legal Name (Last, First, MI, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%

This form is continued. You must complete and return both pages of the form for it to be valid. Please Continue.

Revised March 2019

State of West Virginia Public Employee Insurance Agency
Retiree Optional Life Insurance and Dependent Life Insurance Enrollment Form

RET
OPT/DEP

Dependent Life

Dependent Life Insurance - You may choose to enroll for dependent life for your spouse and/or children. The beneficiary of the dependent life insurance policy is the employee. To enroll for dependent life insurance, mark the plan of your choice and complete the following information.

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4	☐ Plan 5
$5,000 for your spouse $2,000 for each child	$10,000 for your spouse $4,000 for each child	$15,000 for your spouse $7,500 for each child	$20,000 for your spouse $10,000 for each child	$40,000 for your spouse $15,000 for each child

Dependent Legal Name (Last, First, MI, Generation)	Relationship to Insured	Social Security Number	Date of Birth (mm/dd/yy)

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: ☐ Policyholder ☐ Dependent (spouse and/or children)

☐ No Tobacco Users within the last (6) months

Acceptance

I am enrolling in ☐ Optional Life ☐ Dependent Life

☐ The Benefits have been explained to me and I hereby decline to participate.

☐ I hereby accept the Life Insurance. 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.

Employee's Signature: Date:

Agency

Agency Name	Hire Date	Last Date of Active Employment
Account Number	Effective Date of Retirement	Effective Date of Retiree Coverage

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature : Date:

Revised March 2019

Retirement Optional/Dependent Life Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Agency Account Number: Your 9-digit number found on the monthly billing invoice

Hire Date: Enter the date in month, day and year policyholder was hired.

Last date of Active Employment: Date employee was last actively on payroll

Effective Date of Retirement: Date the employee retires

Effective Date of Retiree Insurance Coverage: First day of the month following the date of retirement

OPT Plan: Use the option code below based on the plan chosen by the employee.

Active Employee Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	300
Plan IV	400
Plan V	500
Plan VI	600
Plan VII	650
Plan VIII	700
Plan IX	750
Plan X	800

If an employee chooses more than $100,000 of coverage, he or she will be required to provide Evidence of Insurability. Please see the Life section of the BCRM for further details.

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400
5	500

Please note that if documentation is required for a dependent and cannot be submitted with the Optional and Dependent Life Insurance Enrollment form, the form on page 15 should accompany submission of the documentation to PEIA.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Notice of Death

Notice of Death

Minnesota Life Insurance Company - A Securian Company
Charleston Branch Office • PO Box 3742 • Charleston, WV 25337-3742
Claims • Toll free 1-800-203-9515

MINNESOTA LIFE

TYPE OF CLAIM: ☐ Active Employee ☐ Retiree ☐ Dependent

Attach a certified copy of the official death certificate.

PART 1 - EMPLOYEE INFORMATION (to be completed by the employer)

1. Employee name		2. Employee Social Security number
3. Employee address (street, city, state, zip)		4. Employee telephone number
5. Employee date of hire (mo/day/yr)	6. Effective date of employee's insurance (mo/day/yr)	7. Employee actively at work on effective date? ☐ Yes ☐ No

PART 2 - DECEASED INFORMATION (to be completed by the employer)

1. Name of deceased	2. Deceased's Social Security number	3. Relationship to employee	4. Gender ☐ Male ☐ Female
5. If dependent, effective date of dependent's insurance? (mo/day/yr)	6. Date of birth (mo/day/yr)	7. Date of death (mo/day/yr)	8. Was death due to an accident? ☐ Yes ☐ No

PART 3 - EMPLOYER CERTIFICATION

1. Name of employer, association or fund		2. Telephone number
3. Address of employer, association or fund (street, city, state, zip)		4. Account number
Signature of authorized representative X	Date signed	Title

PART 4 - BENEFICIARY STATEMENT **(You must sign both signature lines below.)** ***(WITHOUT A COMPLETED IRS FORM W-9 BY THE BENEFICIARY, THE BENEFICIARY MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.)***

1. Print name of beneficiary		2. Other names by which the deceased has been known, if any	
3. Relationship to deceased	4. Beneficiary Social Security number	5. Beneficiary date of birth	6. Beneficiary telephone number
7. Beneficiary address (street, city, state, zip)			
Beneficiary signature X			Date

CERTIFICATION INSTRUCTIONS: You must cross out item (2) below if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return.

CERTIFICATION – Under penalties of perjury, I certify that:

(1) The number shown on this form is the beneficiary's correct Social Security number, **and**
(2) The beneficiary is not subject to backup withholding either because he/she has not been notified by the Internal Revenue Service (IRS) that he/she is subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified him/her that he/she is no longer subject to backup withholding, **and**
(3) The beneficiary is a U. S. person (including a U. S. resident alien), **and**
(4) The FATCA code(s) entered on this form (if any) indicating that the beneficiary is exempt from FATCA reporting is correct.
Exempt payee code (if any)_____ Exemption from FATCA reporting code (if any)_____

Certification Notice: THE IRS REQUIRES US TO OBTAIN CERTIFICATION OF YOUR SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER. WITHOUT THIS INFORMATION, YOU MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING FOR ANY INTEREST PAID ON THE DEATH BENEFIT.

Beneficiary signature X	Date

PART 5 - PEIA CERTIFICATION **I certify that on the date of death, the above named was insured under this policy. I further certify that the information provided above is true and correct to the best of my knowledge and belief. (Attach a copy of enrollment form.)**

1. Employer/policyholder name	2. Coverage code	3. Plan/policy number	4. Date to which premiums were paid for deceased (mo/day/yr)
PEIA		33227	

5. Amount of insurance
Basic $_____ Optional $_____ Dependent $_____ Total $_____

Signature of authorized PEIA representative X	Date signed	Telephone number

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

F1471-PEIA Rev 3-2015

Notice of Death

A Benefit Coordinator may call Securian/Minnesota Life at 1-800-203-9515 or 1-304-344-1222 to report the death of a policyholder or dependent. Otherwise, they may fill out the Notice of Death Form.

Part 1- Employee Information

Employee Name: Enter the policyholder's name, Last, first and middle.

Employee Social Security Number: Enter the Social Security number of the policyholder.

Employee Address: Enter the address of the policyholder**.**

Employee Telephone Number: Enter the telephone number of the policyholder.

Employee Date of Hire: Enter the date employment began.

Employee Date of Insurance: Enter the date insurance began.

Actively at Work on Effective date: Mark the correct box.

Part 2 – Deceased Information

Name: Name of the deceased member or dependent

Social Security Number: Enter the Social Security number of the deceased.

Relationship: Enter the relationship of the deceased to the policyholder

Gender: Mark the box for the gender of the deceased.

Dependent effective: If the deceased is a dependent, enter the date insurance was effective for the dependent.

Birthdate: Enter the birthdate of the deceased

Date of Death: Enter the Date of death of the member of dependent.

Accidental: Mark the correct box.

Part 3 – Employer's Certification

Name of employer, association or fund: Your agency name as it appears on your PEIA monthly billing.

Telephone Number: Enter your work phone number.

Address of employer, association or fund: Enter your agency's mailing address.

Account number: Enter the agency account number from your PEIA monthly billing

Signature of authorized representative: Your signature as the Benefit Coordinator

Date signed: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder

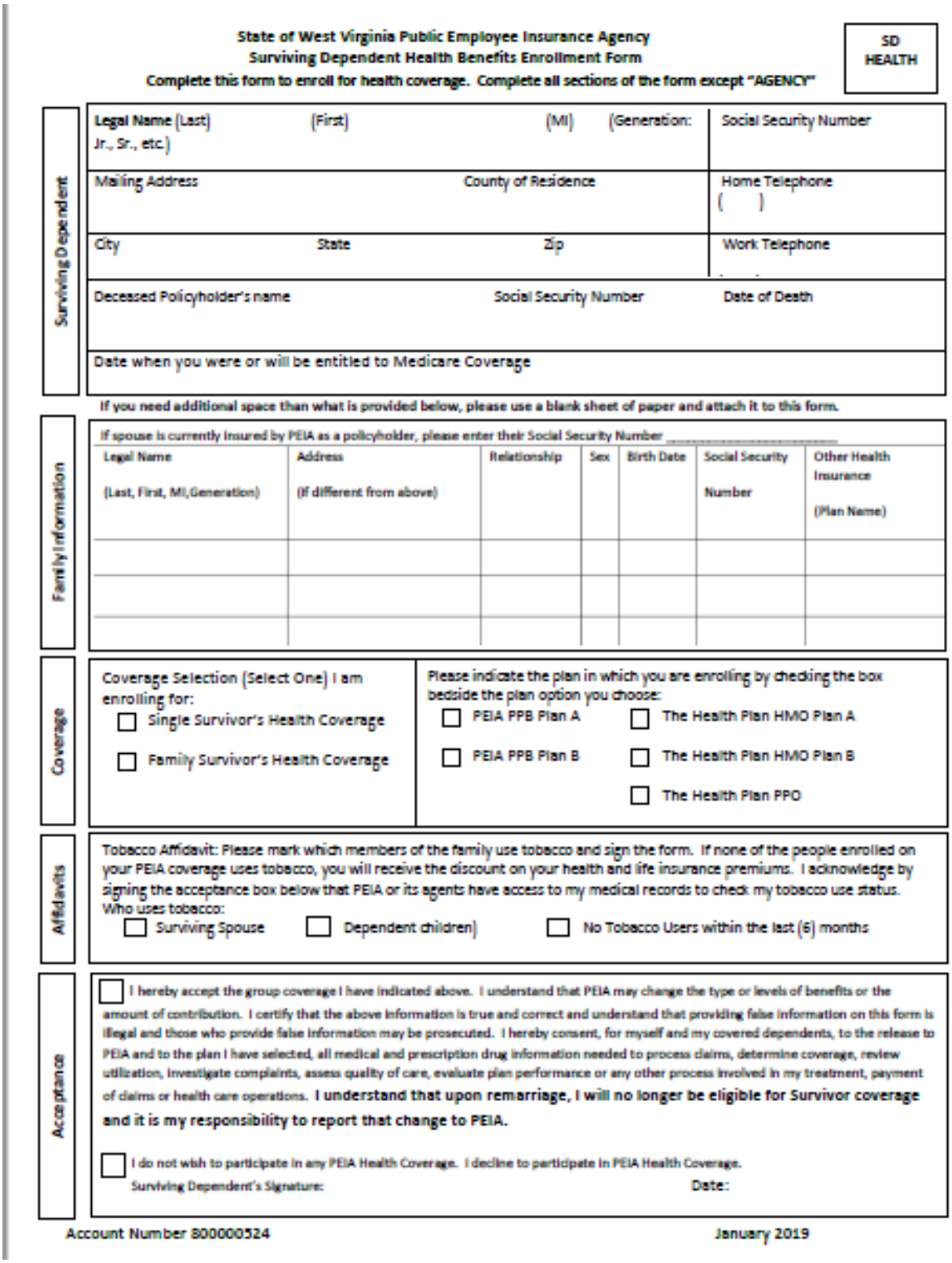
Title: Enter your job title.

Please mail it to:

Securian Charleston Branch Office

P. O. Box 3742, Charleston WV, 25337-3742

Surviving Dependent Enrollment Form



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) Jr., Sr., etc.)	(First)	(MI)	(Generation:	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:

Account Number 800000524 January 2019

This form is not specifically for use by Benefit Coordinators and does not require the Benefit Coordinator's signature. We are including it in this book for your convenience and reference.

Authorization to Remove WCC/BC

Public Employees Insurance Agency

WV Toll-free: 1 (888) 680-7342
Phone: 1 (304) 558-7850
Fax: 1 (877) 233-4295
Website: www.wvpeia.com

Please remove the following individual as an active PEIA:

- ○ Benefit Coordinator
- ○ Web Contributions Coordinator

Employee Name: _____

Employee E-Mail Address: _____

Agency Name: _____

Agency Account Number: _____

Effective Date of Removal: _____

Authorized by (print name): _____

Title: _____ Phone: _____

Signature: _____ Date: _____

601 – 57th Street, SE • Suite 2 • Charleston, WV 25304-2345

Authorization to Remove WCC/BC

It is important to *immediately* remove access of previous WCCs and BCs when they leave your agency.

Mark appropriate circles: Mark which roles from which they need access to be removed.

Employee Name: Enter the employee's name

Employee Email Address: Enter the employee's email address

Agency Name: Enter the name of the Agency

Effective Date of Removal: Enter the effective date of removal from the role(s).

Agency Account Number: Enter your 9-digit number found on the monthly billing invoice.

Authorized By: Write your printed name.

Title: Enter your title.

Telephone Number: Enter your telephone number at your agency.

Signature: Sign your signature.

Date: The date you sign the form. Forms should be signed immediately and emailed or faxed to PEIA.