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 POS 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)

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☐ 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 UMR, who administers COBRA for PEIA. You will have a limited amount of time to elect continuation of coverage.

COBRA premiums include both 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.

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: