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: