State of West Virginia Public Employees Insurance Agency
Surviving Dependent Enrollment Form

Complete this form to enroll for health benefits as a surviving dependent. Mail completed form to PEIA, 601 57th St SE, Suite 2, Charleston, WV 25304

Survivor Information

Full Legal Name: (Last) (First) (MI) Suffix (Jr, Sr, III)		Social Security Number (SSN)
Physical Address: (street address, city, state and zip code)		Date of birth (mm/dd/yyyy)
Mailing Address (if different from above)		Phone Number
Gender ☐ Male ☐ Female	County of Residence	Date you were/will be entitled to Medicare
Deceased Policyholder's Name	Social Security Number	Date of Death

If you do not wish to participate in PEIA coverage, check the box, sign and return this form to the address above.

☐ I decline to participate in any PEIA coverage. Surviving Dependent's Signature: Date:

Family Information

Please list dependents to be enrolled in addition to the survivor above. Dependents must have been covered at the time of the policyholder's death to be eligible for coverage. Dependent children may be covered until age 26.

Full Legal Name (last, first MI, suffix)	Address (if different from above)	Relationship	Sex	Date of Birth	SSN

Coverage Selection If you are continuing coverage upon the death of the policyholder, you will stay in your current plan until the next open enrollment. If you are a survivor enrolling after a lapse in coverage, please choose a plan below.

Choose your coverage

☐ Single Survivor's Health Coverage

☐ Family Survivor's Health Coverage

Non-Medicare Survivors -- Please choose your plan.

☐ PEIA PPB Plan A ☐ The Health Plan HMO Plan A

☐ PEIA PPB Plan B ☐ The Health Plan HMO Plan B

☐ The Health Plan PPO Plan C

Medicare Survivors – Please choose a plan:

☐ Humana/PEIA Plan 1 ☐ Humana/PEIA Plan 2

Tobacco Affidavit

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 child(ren) ☐ No Tobacco Users within the last six (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.**

Surviving Dependent's Signature: Date: