

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

BASIC LIFE

Complete this form to enroll for Basic 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)

Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.

Coverage	Benefit for Active Employees for:	
	\$10,000	

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: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last (6) months

125	Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available?
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Acceptance	<input type="checkbox"/> 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.
	<input type="checkbox"/> 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: _____	