FBMC
BENEFITS MANAGEMENT

ATTN: Mailslot #37
PO BOX 1878
TALLAHASSEE, FL 32302-1878
FAX: 850-514-5803

STATE OF WEST VIRGINIA
EMPLOYEE ENROLLMENT FORM
July 1, 2025 - June 30, 2026

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

1.

INSTRUCTIONS: DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2025

WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?	HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:	CHANGE IN ELECTION
• Newly hired employees who want to enroll for the first time. • Employees who want to add, change or cancel any benefits. • **Existing benefits not indicated on this form will continue as currently enrolled.**	• **IMPORTANT:** If you want to add, change or cancel coverage, you must check the box beside the appropriate benefit in Section 3. Indicate coverage levels and any other pertinent information. • If you select dependent coverage for any benefit, you must provide dependent information in Section 4.	• Include supporting documentation. • Must be requested within the month of and two months following your status changing event. • List all eligible dependents you want covered.

2.

SSN#	E-MAIL	☐ Open Enrollment ☐ Transfer	☐ New Hire ☐ Change in Status

LAST NAME	FIRST NAME	MI

HOME ADDRESS [STREET]	CITY	STATE	ZIP	HOME PHONE

BIRTH DATE	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	DATE EMPLOYED	EFFECTIVE DATE	CELL PHONE

3.

MOUNTAINEER FLEXIBLE BENEFITS (PAID BY EMPLOYEES)

Keep Coverage	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS If you select Employee & DEPENDENT coverage, you must complete the dependent information in Section 4.		COST PER PAY PERIOD
				POST-TAX BENEFITS		
☐	☐	☐	☐	**HOSPITAL INDEMNITY INSURANCE**	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	**CRITICAL ILLNESS INSURANCE** Refer back to your benefit guide for rates and rules.	☐ Employee Only: Benefit amount _____ ☐ Spouse Only: Benefit amount _____ ☐ Children Only: Benefit amount _____	
☐	☐	☐	☐	**ACCIDENT INSURANCE**	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	**LEGAL** ☐ Ultimate Advisor® Employee & Family ☐ Ultimate Advisor Plus™ Employee & Family		
				POST-TAX SALARY DEDUCTION AMOUNT PER PAY PERIOD		
				PRETAX BENEFITS		
☐	☐	☐	☐	**DENTAL** Choose One Option: ☐ Assistance ☐ Basic ☐ Enhanced ☐ Premier	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	**VISION** Choose One Option: ☐ Exam Plus ☐ Full Service	☐ Employee Only ☐ Employee & Family	
☐	☐	☐	☐	**HEARING SERVICE PLAN**	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	**HEALTH CARE FLEXIBLE SPENDING ACCOUNT** All Claims Must Be Submitted By **October 31, 2026.**		
☐	☐	☐	☐	**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT** All Claims Must Be Submitted By **October 31, 2026.** ☐ Married, Filing Separately ☐ Married, Filing Jointly ☐ Single, Head Of Household		
☐	☐	☐	☐	**HEALTH SAVINGS ACCOUNT** Must be enrolled in PEIA Plan C. Contribution Is Per Pay Period. You cannot enroll in a Health Care Flexible Spending Account.	Select your HSA coverage type: ☐ Individual ($4,300 maximum for PY 2026) ☐ Family ($8,550 maximum for PY 2026) ☐ Over 55 Catch-up (additional maximum $1,000)	
☐	☐	☐	☐	**LONG-TERM DISABILITY INCOME PLAN** Employee Only	☐ 50% Coverage Level ☐ 60% Coverage Level ☐ 70% Coverage Level (currently enrolled only)	
☐	☐	☐	☐	**SHORT-TERM DISABILITY INCOME PLAN** Employee Only		
☐	☐	☐	☐	**LIMITED HEALTH CARE FSA** Must be enrolled in HSA.		
				TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD		

MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

FBMC
BENEFITS MANAGEMENT
ATTN: Mailslot #37
PO BOX 1878
TALLAHASSEE, FL 32302-1878
FAX: 850-514-5803

STATE OF WEST VIRGINIA
EMPLOYEE ENROLLMENT FORM
July 1, 2025 - June 30, 2026

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

4

ELIGIBLE DEPENDENT INFORMATION

USE AN ADDITIONAL SHEET OF PAPER AS NEEDED FOR ADDITIONAL DEPENDENTS.

DEPENDENT NAME	RELATIONSHIP	MALE/ FEMALE	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED						
					DENTAL	VISION	HEARING	LEGAL	ACCIDENT INSURANCE	CRITICAL ILLNESS	HOSPITAL INDEMNITY
	Spouse										

DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2025

I hereby authorize my Employer to reduce my gross salary by the total per pay period cost of the benefits selected above. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS PERMITTED BY THE PLAN AND THE IRS. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FBMC BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

DURING OPEN ENROLLMENT, GIVE COMPLETED FORMS TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2025.

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED

FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)

HSA EMPLOYEES MUST BE ENROLLED IN PEIA PLAN C OR ANOTHER ELIGIBLE HDHP.

AGENCY NAME _____

4 DIGIT WORK LOCATION # _____

EFFECTIVE DATE _____

NO. PAY DEDUCTIONS _____

GROSS ANNUAL SALARY _____

BENEFIT COORDINATOR SIGNATURE _____

SIGNATURE DATE _____

BENEFIT COORDINATOR PHONE# ( ) _____

BENEFIT COORDINATOR FAX# ( ) _____

ENROLLMENT FORMS SHOULD BE MAILED TO: **FBMC, PO BOX 1878,TALLAHASSEE, FL 32302-1878** DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY **MAY 23, 2025.**

MAKE A COPY OF THIS FORM FOR YOUR RECORDS.