FBMC BENEFITS MANAGEMENT

Attention
Mailslot 32

RETIREE DIRECT BILL, PO BOX 10789
TALLAHASSEE, FL 32302-2789
FAX: 866-836-9943

2020 STATE OF WEST VIRGINIA RETIREE ENROLLMENT FORM

July 1, 2019 - June 30, 2020

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

19WV_RETFORM

1 **INSTRUCTIONS: You do not need to complete the form if you wish to continue your current retiree benefits without changes.** New retirees or surviving spouses must complete this application to enroll for coverage. If you enroll or make changes, mail the form to **FBMC/Direct Bill, PO Box 10789, Tallahassee, FL 32302-2789** or, fax to 866-836-9943. Please complete the dependent information section if you select coverage that includes dependents.

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SOCIAL SECURITY#	EFFECTIVE DATE (First day of month)	☐ OPEN ENROLLMENT ☐ NEW RETIREE ☐ CONTINUE EXISTING COVERAGE ☐ OTHER	CHOOSE ONE: ☐ Pay by check (includes TIAA-CREF)* ☐ Deduct from CPRB Retirement check**

LAST NAME (RETIREE OR SURVIVING SPOUSE)	FIRST NAME (RETIREE OR SURVIVING SPOUSE)	MI

MAILING ADDRESS (STREET)

CITY	STATE	ZIP	BIRTH DATE	☐ MALE ☐ FEMALE

HOME PHONE	☐ MARRIED ☐ SINGLE ☐ SURVIVING SPOUSE	E-MAIL

* If you choose to pay by check, you will receive a monthly billing statement to mail in your monthly premium.

** If you choose deductions through CPRB, your premium will be deducted from your check in advance (For example, July's premium will be deducted in June). You will receive an Enrollment Summary Report upon enrolling, which will include where to submit your monthly premium until CPRB deductions begin.

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MONTHLY RETIREE RATES

DELTA DENTAL	ROUTINE	ASSISTANCE	BASIC	ENHANCED
☐ Cancel Dental Coverage	☐ Retiree Only $11.17 ☐ Retiree & Children* $22.40 ☐ Retiree & Spouse* $24.99 ☐ Retiree & Family* $36.28	☐ Retiree Only $12.07 ☐ Retiree & Children* $24.20 ☐ Retiree & Spouse* $27.00 ☐ Retiree & Family* $39.19	☐ Retiree Only $17.27 ☐ Retiree & Children* $34.58 ☐ Retiree & Spouse* $38.54 ☐ Retiree & Family* $55.89	☐ Retiree Only $28.72 ☐ Retiree & Children* $57.44 ☐ Retiree & Spouse* $66.70 ☐ Retiree & Family* $95.28

METLIFE VISION	EXAM PLUS		FULL SERVICE	
☐ Cancel Vision Coverage	☐ Retiree Only $1.33	☐ Retiree & Family* $3.03	☐ Retiree Only $7.74	☐ Retiree & Family* $19.69

EPIC HEARING SERVICE				
☐ Cancel Hearing Coverage	☐ Retiree Only $1.96	☐ Retiree & Children* $2.88	☐ Retiree & Spouse* $3.89	☐ Retiree & Family* $4.80

ARAG LEGAL	
☐ Cancel Legal Coverage	☐ Retiree & Family* $11.50

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***IF YOU SELECT DEPENDENT COVERAGE FOR ANY OF THE BENEFITS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.**

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
	SPOUSE							

I hereby authorize the WV Consolidated Public Retirement Board to deduct my insurance premiums from my monthly benefit check and make any subsequent premium changes as directed. For Retirees who did not elect to have premiums deducted from CPRB: I agree to remit payment to FBMC Benefits Management, Inc.

RETIREE SIGNATURE	DATE SIGNED