FBMC
BENEFITS MANAGEMENT
ATTN: Mailslot #32
PO BOX 10789
TALLAHASSEE, FL 32302-2789
FAX: 866-836-9943

STATE OF WEST VIRGINIA
RETIREE ENROLLMENT FORM
July 1, 2026 - June 30, 2027

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

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. Be sure to make a copy for your records before mailing back to FBMC. **Return completed form to FBMC no later than May 15, 2026.**

2.

SSN#	EFFECTIVE DATE (First day of month)	TYPE OF ENROLLMENT: ☐ Open Enrollment ☐ New Retiree ☐ Continue Existing Coverage ☐ Other	PAYMENT OPTIONS (Choose One): ☐ Pay by ACH - **(Complete back page of enrollment form)** ☐ Deduct from CPRB Retirement check[1] ☐ Pay by Check (Includes TIAA-CREF)[2]

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	CELL PHONE	☐ Married ☐ Single ☐ Surviving Spouse	E-MAIL

[1] 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.

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

3.

MONTHLY RETIREE RATES

DENTAL	ASSISTANCE	BASIC	ENHANCED	PREMIER
☐ Cancel Dental Coverage	☐ Retiree Only $16.06	☐ Retiree Only $22.70	☐ Retiree Only $32.01	☐ Retiree Only $41.73
	☐ Retiree & Children[3] $32.20	☐ Retiree & Children[3] $45.46	☐ Retiree & Children[3] $64.08	☐ Retiree & Children[3] $83.89
	☐ Retiree & Spouse[3] $35.93	☐ Retiree & Spouse[3] $50.67	☐ Retiree & Spouse[3] $74.41	☐ Retiree & Spouse[3] $97.73
	☐ Retiree & Family[3] $52.15	☐ Retiree & Family[3] $73.47	☐ Retiree & Family[3] $106.28	☐ Retiree & Family[3] $139.72

VISION	EXAM PLUS		FULL SERVICE	
☐ Cancel Vision Coverage	☐ Retiree Only $1.13	☐ Retiree & Family[3] $2.58	☐ Retiree Only $6.60	☐ Retiree & Family[3] $16.78
HEARING SERVICE				
☐ Cancel Hearing Coverage	☐ Retiree Only $1.82	☐ Retiree & Children[3] $2.67	☐ Retiree & Spouse[3] $3.61	☐ Retiree & Family[3] $4.45
LEGAL				
☐ Cancel Legal Coverage	☐ Ultimate Advisor® Retiree & Family[3] $9.50		■ Ultimate Advisor Plus™ Retiree & Family[3] $13.90	

[3] If you select dependent coverage for any of the benefits above, you must complete the information below.

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

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. or have FBMC Benefits Management, Inc deduct payments for my monthly premium owed based on my enrollment elections.

RETIREE SIGNATURE	DATE SIGNED

Make a copy of this form for your records.

Turn over for ACH Authorization Form

FBMC
BENEFITS MANAGEMENT
Direct Debit (ACH) Form
Monthly Premium Billing Payments

STATE OF WEST VIRGINIA
ACH AUTHORIZATION FORM

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

Participant Information:

NEW ACH ☐ CHANGE ACH ☐ CANCEL ACH ☐

Former Employer Name: _____

Participant Name: (Please Print) _____

Street Address: _____

City, State, ZIP Code: _____

Telephone #: (_____) _____-_____

Financial Institution Information:

Name of Financial Institution: _____

Account Type: CHECKING ☐ SAVINGS ☐

Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

**Routing number is the first 9 digits reflected in the bottom left corner of your check. Please attach a voided check of the account number that the direct debit will be drawn against. If you have elected Savings, please provide verification letter for your Savings Account.*

Authorization

I hereby authorize **FBMC** to direct debit my account on the dates due for all monthly premium billing payments, including premiums due for myself and eligible dependents. This authorization remains in effect until FBMC receives my written notification to rescind this authorization in time to allow reasonable opportunity to act on my instructions. I also understand that until such time that the bank has finalized the direct debit process, I must continue to send my monthly premiums via check or money order directly to FBMC to avoid any interruption or cancellation of coverage.

FBMC will process your scheduled monthly premium payments for direct debit from your designated account by the 10th day of each month. Should the payment date fall on a weekend or holiday, the debit will be deducted on the next business day. If funds in your designated account are insufficient to cover the premium payment required, **FBMC** will require you to remit a check for the full premium amount in order to prevent termination of coverage.

Participant's Signature: _____ Date: _____

Attach Voided Check Here

(*Note: If a voided check from your checking account or a bank verification letter for a savings account is not attached, this form will be returned to you.)