

**State of West Virginia Public Employee Insurance Agency
Policyholder Termination of Coverage Form**

TERM

Complete this form to terminate health/life coverage. Complete all sections of the form except "AGENCY"

Employee	Full 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) _____

If your spouse is currently insured by PEIA as a policyholder, please provide the Social Security Number _____

Termination Reason	<p>***Participants cannot voluntarily terminate a benefit without a qualifying event. If you are requesting this action outside of open enrollment period, please state the qualifying event and attach documentation to support the event. Please refer to the Summary Plan Description for further details and a list of qualifying events.</p>	
	<input type="checkbox"/> Resignation (B.C: if transferring to another PEIA insured agency, please use the online transfer function in Manage My Benefits)	
	<input type="checkbox"/> Terminated for Misconduct (If an Administrative appeal is being instituted, please complete the <i>Administrative Appeal</i> section of this form)	
	<input type="checkbox"/> Terminated Involuntarily or by reduction in work force. I <input type="checkbox"/> do <input type="checkbox"/> do not accept the (3) additional months of extended benefits.	
	<input type="checkbox"/> Voluntarily cancel all coverage. Re-enrollment restrictions may apply*** (To cancel health insurance only, use a Change in Status form)	
	<input type="checkbox"/> Retirement	
	<input type="checkbox"/> Cancellation of Employee Basic Life insurance***	
	<input type="checkbox"/> Cancellation of Employee Optional Life insurance***	
	<input type="checkbox"/> Cancellation of Dependent Optional Life Insurance***	
	<input type="checkbox"/> Deceased (Please enter the date of death) _____	
<input type="checkbox"/> Surviving Dependent Remarriage (Please enter the date of Marriage) _____		
<input type="checkbox"/> Termination (If policyholder is unavailable for signature, Form must be signed the BC and by another staff member of the agency)		
<input type="checkbox"/> Affordable Care Act		
<input type="checkbox"/> Other (Please explain) _____		
Required Policyholder Signature: _____ Date: _____		

Administrative Appeal	<p>In the case of a termination for misconduct, you may have the right to an administrative appeal. If the administrative appeal is to be instituted, with your employer's approval, you may continue to pay your "employee's share" of the monthly premium. If you lose the appeal, and have elected to continue your coverage for these additional months, you will be required to reimburse the total premium for the months during which you have continued your coverage. Please mark your choice:</p>	
	<input type="checkbox"/> I elect to continue coverage during the administrative appeal, realizing fully that if my appeal is lost, I am responsible for reimbursing the entire premium to the agency or to the State of West Virginia.	
	<input type="checkbox"/> I decline to continue coverage during the administrative appeal.	
Policyholder Signature: _____ Date: _____		

COBRA	<p>Under federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by UMR, PEIA's COBRA administrator. You will have a limited amount of time to elect continuation of coverage. COBRA premiums include both the employer and employee share of the premium, as well as an administrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact UMR at 1-888-440-7342.</p>
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Agency	Agency Name _____	Account Number _____	Current Coverage Code _____	
	Date off Payroll _____	Effective Date of Termination _____		
	I hereby certify that to the best of my knowledge, the information contained herein is accurate.			
	Benefit Coordinator Signature: _____		Date: _____	
	Agency Authorized Signature: _____		Title: _____	
Date: Signed: _____				