

State of West Virginia Public Employee Insurance Agency
Retiree Optional Life Insurance and Dependent Life Insurance Enrollment Form



Complete this form to enroll for Opt/Dep 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
	City State Zip	Home Telephone ()
	Physical Address	Sex (Circle one) M F
	City State Zip	Date of Birth (mm/dd/yy)

You Must be enrolled with BASIC LIFE to enroll in Optional and/or Dependent Life. If you have not enrolled for Basic Life, please fill out a Retiree Basic Life and Health Enrollment Form to enroll in Basic Life prior to submitting this form.

Optional Life	Optional Life Insurance- If you have enrolled in basic Life insurance you may choose to enroll for optional life for yourself. Your coverage is based on your selection and your age on the effective date of coverage. If you need additional space please use a blank sheet of paper and attach it.									
	Employee's Age <input type="checkbox"/>	Plan 1	<input type="checkbox"/>	Plan 2	<input type="checkbox"/>	Plan 3	<input type="checkbox"/>	Plan 4	<input type="checkbox"/>	Plan 5
	Under Age 65	\$5,000		\$10,000		\$15,000		\$20,000		\$30,000
	Age 65 to 69	3,250		6,500		9,750		13,000		19,500
	Age 70 and above	2,500		5,000		7,500		10,000		15,000
	Employee's Age <input type="checkbox"/>	Plan 6	<input type="checkbox"/>	Plan 7	<input type="checkbox"/>	Plan 8	<input type="checkbox"/>	Plan 9	<input type="checkbox"/>	Plan 10
	Under Age 65	\$40,000		\$50,000		\$75,000		\$100,000		\$150,000
	Age 65 to 69	26,000		32,500		48,750		65,000		97,500
	Age 70 and above	20,000		25,000		37,500		50,000		75,000
	<p>PEIA no longer stores Beneficiary information.</p> <p>Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.</p>									

This form is continued. You must complete and return both pages of the form for it to be valid. Please Continue.

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Dependent Life

Dependent Life Insurance - You may choose to enroll for dependent life for your spouse and/or children. The beneficiary of the dependent life insurance policy is the employee. To enroll for dependent life insurance, mark the plan of your choice and complete the following information.

<input type="checkbox"/> Plan 1 \$5,000 for your spouse \$2,000 for each child	<input type="checkbox"/> Plan 2 \$10,000 for your spouse \$4,000 for each child	<input type="checkbox"/> Plan 3 \$15,000 for your spouse \$7,500 for each child	<input type="checkbox"/> Plan 4 \$20,000 for your spouse \$10,000 for each child	<input type="checkbox"/> Plan 5 \$40,000 for your spouse \$15,000 for each child
Dependent Legal Name (Last, First, MI, Generation)		Relationship to Insured	Social Security Number	Date of Birth (mm/dd/yy)

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 uses tobacco, you will receive the discount on your health and 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: Policyholder Dependent (spouse and/or children)

No Tobacco Users within the last (6) months

Acceptance

I am enrolling in Optional Life Dependent Life

The Benefits have been explained to me and I hereby decline to participate.

I hereby accept the 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.

Employee's Signature: _____ Date: _____

Agency

Agency Name	Hire Date	Last Date of Active Employment
Account Number	Effective Date of Retirement	Effective Date of Retiree Coverage

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: _____