

**State of West Virginia Public Employee Insurance Agency  
Health Benefits Enrollment Form**

**Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY." This is a 2-page form. You must complete and submit both pages to enroll in the plan. If page 2 is not submitted with page 1, you will not be enrolled for health coverage.**

Employee	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/yyyy)
Email Address:				

If you need more space than what is provided below, please use a blank sheet of paper and attach it to this form.

Dependent Information	If spouse is currently insured by PEIA as a policyholder, please enter their Social Security Number _____					
	Legal Name (Last, First, MI, Generation)	Address (if different from above)	Relationship	Sex	Birth Date	Social Security #

Coverage	Coverage Selection (Select One) I am enrolling for:		Please indicate the plan in which you are enrolling by checking the box to the left of the plan option you choose:			
	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>	PEIA PPB Plan A	<input type="checkbox"/>	The Health Plan HMO Plan A
	<input type="checkbox"/>	Employee/Child(ren) Only	<input type="checkbox"/>	PEIA PPB Plan B	<input type="checkbox"/>	The Health Plan HMO Plan B
	<input type="checkbox"/>	Family	<input type="checkbox"/>	PEIA PPB Plan C	<input type="checkbox"/>	The Health Plan POS
		<input type="checkbox"/>	PEIA PPB Plan D			

**Proceed to page 2. This form is not valid if page 2 is not completed and submitted.**

