

Basic Life Insurance Enrollment Form

State of West Virginia Public Employee Insurance Agency
Basic Life Enrollment Form

BASIC LIFE

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

Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.

Coverage	Benefit for Active Employees for:
	\$10,000

Affidavits	<p>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 use tobacco, you will receive the discount on your health and Opt/Dep 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.</p> <p>Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last (6) months</p>
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125	<p>Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Acceptance	<p><input type="checkbox"/> I hereby accept the Basic 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.</p> <p><input type="checkbox"/> I do not wish to participate in PEIA Basic Life Insurance. I decline to participate in Basic Life Insurance.</p>
	<p>Employee's Signature: _____ Date: _____</p>

Agency	Agency Name	Account Number	Date of Employment
	Hours worked Weekly	Effective Date of Coverage	Coverage Code
	Index Code		
<p>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.</p>			
Authorized Signature		Date:	

8/2024

Basic Life Insurance Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit agency account number as it appears on your billing.

Date of Employment: Date Employee was hired or the date he or she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms and returns it to you to elect the coverage), if it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application; PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. Minnesota Life will contact you when the medical underwriting decision has been made. Please see the Life section of the BCRM for further details. The employee must be actively at work for coverage to begin. If the employee is not actively at work due to illness or injury on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Coverage Code: Mark with code LB01 for basic life.

Index Code: Choose the code from the appropriate charts on Page 2 and 3 that reflects the employee's annual salary.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Health Benefits Enrollment Form

HEALTH

**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				Home Telephone
	County of Residence				
	City				Work Telephone
	State				
Zip					
Physical Address					Sex (Circle one)
					M F
City					Date of Birth
State					(mm/dd/yyyy)
Zip					
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.

Health Benefits Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Date of Employment: Date Employee was hired or the date he/ she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms to elect the coverage). Remember that the employee must be actively at work for coverage to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work. If paperwork is not sent in until the month after employment began, coverage may not begin until the first of the following month and there may be a lapse in coverage.

Index Code: Choose the code from the appropriate chart below to reflect the employee's annual salary

Non-State Agencies Do Not fill in an Index Code.

For State Agencies, Colleges, Universities and County Boards of Education For the PEIA PPB Plan A and ALL managed care coverages	
IDX	
1	\$0 - \$30,400
2	\$30,401 - \$40,400
3	\$40,401 - \$46,400
4	\$46,401 - \$52,400
5	\$52,401 - \$60,400
6	\$60,401 - \$72,900
7	\$72,901 - \$85,400
8	\$85,401 - \$110,400
9	\$110,401 - \$135,400
10	\$135,401+

Coverage Code: Please use one of the codes below to indicate which plan the policyholder chose:

HI01	PEIA PPB Plan A
HI02	PEIA PPB Plan B
HI03	PEIA PPB Plan C
HI04	PEIA PPB Plan D
HMHP - A	The Health Plan HMO Plan A
HMHP - B	The Health Plan HMO Plan B
HMHP – C	The Health Plan HMO Plan C

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Policyholder Only

F = Policyholder, Spouse and Children

C = Policyholder and Children Only

S = Policyholder and Spouse Only (generates same premium as F)

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. If the addition of health coverage creates as ESPS situation, PEIA needs to be aware of the IDX change if applicable so that it may be made at time of entry into the PEIA system. PEIA does not have access to salaries.

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-F**.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Optional and Dependent Life Insurance Enrollment Form (OPT)

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

OPT/DEP

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	Work Telephone ()
	City State Zip	Sex (Circle one) M F Date of Birth (mm/dd/yy)

Optional Life Insurance

**** An asterisk beside the plan number means Guaranteed Issue for New Hires within their initial enrollment period.**

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**	<input type="checkbox"/> Plan 6**	<input type="checkbox"/> Plan 7**	<input type="checkbox"/> Plan 8**	<input type="checkbox"/> Plan 9**
Under Age 45	\$5,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$75,000	\$80,000
Age 45 to 64	3,250	4,500	11,000	18,500	24,000	32,500	38,000	48,750	53,000
Age 65 and	3,250	4,500	9,000	13,500	18,000	22,500	27,000	33,750	36,000
Employee's Age	<input type="checkbox"/> Plan 10**	<input type="checkbox"/> Plan 11	<input type="checkbox"/> Plan 12	<input type="checkbox"/> Plan 13	<input type="checkbox"/> Plan 14	<input type="checkbox"/> Plan 15	<input type="checkbox"/> Plan 16	<input type="checkbox"/> Plan 17	<input type="checkbox"/> Plan 18
Under Age 45	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	\$350,000	\$400,000	\$450,000	\$500,000
Age 45 to 64	65,000	97,500	130,000	162,500	195,000	227,500	260,000	292,500	325,000
Age 65 and	45,000	67,500	90,000	112,500	135,000	157,500	180,000	202,500	225,000

PEIA no longer stores Beneficiary information.
Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.

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)

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 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.

I do not wish to participate in PEIA OPT/Dep Life Insurance. I decline to participate in OPT/Dep Life Insurance.

Employee's Signature: _____ Date: _____

Agency

Agency Name	Account Number	Date of Employment
Hours worked Weekly	Effective Date of Coverage	OPT Plan code Dep Plan Code

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: _____

Revised June 2022

Optional and Dependent Life Insurance Enrollment Form (OPT)

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit agency account number as it appears on your billing.

Date of Employment: Date of full-time employment for the employee with your agency.

Hours Worked Weekly: Number of hours the employee works each week.

Effective Date of Coverage: When completing the form, enter the first day of the month following date of enrollment, (the date the employee signs the form and returns it to you to elect the coverage) if it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application provided by the life insurance carrier. PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. Minnesota Life will contact you when the medical underwriting decision has been made. Please see the Life section of the BCRM for further details. The employee must be actively at work for coverage (or an increase in the amount of coverage) to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

OPT Plan: Use the option code below based on the plan chosen by the employee.

Active Employee Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	300
Plan IV	400
Plan V	500
Plan VI	600
Plan VII	650
Plan VIII	700
Plan IX	750
Plan X	800
Plan XI	900
Plan XII	950
Plan XIII	951
Plan XIV	952
Plan XV	953
Plan XVI	954
Plan XVII	955
Plan XVIII	956

If an employee chooses more than \$100,000 of coverage, he or she will be required to provide Evidence of Insurability. Please see the Life section of the BCRM for further details.

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400
5	500

Please note that if documentation is required for a dependent and cannot be submitted with the Optional and Dependent Life Insurance Enrollment form, the form on page 12 should accompany submission of the documentation to PEIA.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Change - In - Status Form

State of West Virginia Public Employee Insurance Agency
Change-in-Status Form

CIS

Complete this form to Change your coverage. Complete all sections of the form except "AGENCY." Active employees return form to your benefit coordinator; retired employees mail this form to PEIA, 601 57th St, SE, Suite 2, Charleston, WV 25304-2345 or fax to 1-877-233-4295. This is a 2-page form. You must complete and submit both pages to change your coverage.

Employee	Full Legal Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security #/Member ID #	
	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)
	Email Address:					

Change in Status Reason	<p>Please indicate the status change you are making:</p> <p><input type="checkbox"/> Name Change: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (Last) _____ (First) _____ (MI) _____</p> <p><input type="checkbox"/> Add Dependents to: <input type="checkbox"/> Health <input type="checkbox"/> Dependent Life <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</p> <p style="font-size: small;">Complete Dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.</p> <p><input type="checkbox"/> Remove Dependents from: <input type="checkbox"/> Health <input type="checkbox"/> Dependent Life: <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</p> <p><input type="checkbox"/> Change in Health Coverage from Plan _____ to Plan _____</p> <p><input type="checkbox"/> Add Health Coverage <input type="checkbox"/> PEIA PPB Plan A <input type="checkbox"/> PEIA PPB Plan B <input type="checkbox"/> PEIA PPB Plan C <input type="checkbox"/> PEIA PPB Plan D</p> <p style="font-size: small; margin-left: 40px;"><input type="checkbox"/> The Health Plan HMO Plan A <input type="checkbox"/> The Health Plan HMO Plan B <input type="checkbox"/> The Health Plan POS Plan C</p> <p><input type="checkbox"/> Drop Health Coverage. Keep Life Insurance Only. This terminates Health Coverage for Policyholder and all dependents.</p> <p><input type="checkbox"/> Tobacco Status Change</p> <p><input type="checkbox"/> Other, Please Specify _____</p> <p style="font-size: small;">For each Qualifying event PEIA requires documentation. To add a dependent, PEIA requires documentation to substantiate legal dependency. Please see your Benefit Coordinator for questions about necessary documentation. The member's name, social security number and agency of employment must be written across the top of all documents submitted to PEIA.</p> <p>NOTE: If you have Mountaineer Flexible Benefits, you must update that plan separately by completing an FBMC enrollment form. Please visit https://peia.wv.gov/Forms-Downloads/Pages/Mountaineer-Flexible-Benefits.aspx for more information.</p>
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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 Number or Member ID Number

June 2023

Change - In - Status Form

Change In Status Form Page 2

This page must be signed and accompany page 1 when the form is submitted or your change will not be made.

Status Change Reason	<input type="checkbox"/> Marriage	<input type="checkbox"/> Death of a dependent	<input type="checkbox"/> Open Enrollment
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth of a Child	<input type="checkbox"/> Affordable Care Act
	<input type="checkbox"/> Unpaid Leave of Absence by Employee, Spouse or Dependent	<input type="checkbox"/> Significant Change in Health Coverage	<input type="checkbox"/> Change from full-time to part-time or vice versa of the employee, spouse or dependent
	<input type="checkbox"/> Adoption	<input type="checkbox"/> Beginning or end of a dependent's employment	<input type="checkbox"/> Other (Please Specify):
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 HealthSmart Solutions, who administers COBRA for PEIA. 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 1-888-940-7342.</p> <p>If different than the policyholder's address, please provide the dependent's mailing address below:</p> <p>Dependent Name: _____</p> <p>Street Name: _____</p> <p>City, State and Zip: _____</p>		
	<p>Tobacco Affidavit: Please mark which members of the family use tobacco and sign the form. If no one on your PEIA coverage uses tobacco, you will receive the discount on your health and Optional 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:</p> <p><input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children)</p> <p><input type="checkbox"/> No Tobacco Users within the last (6) months</p>		
Affidavits	<p>Spousal Surcharge Affidavit: For active employees of state agencies, colleges, universities, and county boards of education, if enrolling for family coverage, please mark the box that identifies your spouse's insurance coverage status. If your spouse has employer-sponsored coverage available and remains on your PEIA coverage, you will be assessed a surcharge. Please mark the statement that applies to your spouse:</p> <p><input type="checkbox"/> My spouse does not have health coverage available through his/her employer; is not employed, has Medicare, Medicaid, or Tri-Care, or is retired. (No surcharge will be applied.)</p> <p><input type="checkbox"/> My spouse is employed by a PEIA-participating agency. (No surcharge will be applied.) Name of agency: _____</p> <p><input type="checkbox"/> My spouse has health coverage available through his/her employer. (I understand that if my spouse is on my PEIA health coverage, the monthly premium surcharge will be applied to my premium.)</p>		
	<p><input type="checkbox"/> I hereby accept the group coverage I have indicated above. 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. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.</p> <p>Employee's Signature: _____ Date: _____</p>		
Acceptance	<p>Agency Name _____ Account Number _____</p> <p>Effective Date of Status Change _____ Index Code _____</p>		
	<p>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.</p> <p>Authorized Signature: _____ Date: _____</p>		
Agency	<p>Agency Name _____ Account Number _____</p> <p>Effective Date of Status Change _____ Index Code _____</p>		
	<p>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.</p> <p>Authorized Signature: _____ Date: _____</p>		

Change - In - Status Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Effective Date of This Status Change: Typically, this date is the 1st day of the following month the employee has signed to elect the change. For example, if the Change in Status is dated Jan 28, 2017 by the employee, the effective date would be February 1, 2017.

In the case of a newborn or adopted child, the effective date may be retroactive. For **newborns** added within the month of birth and the two following calendar months effective date of coverage is the date of the child's birth. For **adopted children** if added within the month of adoption or the following two calendar months, the effective date of coverage is retroactive to the date the child was placed in the home or the date the policyholder became financially responsible for the adopted child.

Index Code: Choose the code from the appropriate chart below to reflect the employee's annual salary.

For State Agencies, Colleges, Universities and County Boards of Education For the PEIA PPB Plans A & B and ALL managed care coverages	
IDX	
1	\$0 - \$30,400
2	\$30,401 - \$40,400
3	\$40,401 - \$46,400
4	\$46,401 - \$52,400
5	\$52,401 - \$60,400
6	\$60,401 - \$72,900
7	\$72,901 - \$85,400
8	\$85,401 - \$110,400
9	\$110,401 - \$135,400
10	\$135,401+

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Change - In - Address Form

**State of West Virginia Public Employee Insurance Agency
Change In Address Form**

CIA

Complete this form to Change the Address for you or your dependents.
Complete all sections of the form except "AGENCY"

Please Note: Changing your address with PEIA does not update the information with Mountaineer Flexible Benefits. You must also complete a Demographic Change form and send it to FBMC to update your information in their system.

Employee	Full Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)			Social Security Number
	Old 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)
New Address	New Mailing Address		County of Residence	
	City	State	Zip	
	Physical Address			
	City	State	Zip	
Dependent	Legal Name (Last, First, MI, Generation)	New Address (if different from above)		
Signature	Agency Name			
	I hereby certify that to the best of my knowledge, the information contained herein is accurate and that providing false information on this form is illegal and those who provide false information may be prosecuted.			
	Policyholder's Signature:		Date:	

August 2017

This form is not specifically for use by Benefit Coordinators and does not require the Benefit Coordinator's signature. We are including it in this book for your convenience and reference.

Policyholder Termination of Coverage Form

**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 ()	Work Telephone ()
	City State Zip	Sex (Circle one) M F
	Physical Address	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> <p><input type="checkbox"/> Resignation (B.C. If transferring to another PEIA insured agency, please use the online transfer function in Manage My Benefits)</p> <p><input type="checkbox"/> Terminated for Misconduct (If an Administrative appeal is being instituted, please complete the Administrative Appeal section of this form)</p> <p><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.</p> <p><input type="checkbox"/> Voluntarily cancel all coverage. Re-enrollment restrictions may apply*** (To cancel health insurance only, use a Change in Status form)</p> <p><input type="checkbox"/> Retirement</p> <p><input type="checkbox"/> Cancellation of Employee Basic Life Insurance***</p> <p><input type="checkbox"/> Cancellation of Employee Optional Life Insurance***</p> <p><input type="checkbox"/> Cancellation of Dependent Optional Life Insurance***</p> <p><input type="checkbox"/> Deceased (Please enter the date of death) _____</p> <p><input type="checkbox"/> Surviving Dependent Remarriage (Please enter the date of Marriage) _____</p> <p><input type="checkbox"/> Termination (If policyholder is unavailable for signature, form must be signed the BC and by another staff member of the agency)</p> <p><input type="checkbox"/> Affordable Care Act</p> <p><input type="checkbox"/> Other (Please explain) _____</p>
	<p>Required Policyholder Signature: _____ Date: _____</p>

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> <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.</p> <p><input type="checkbox"/> I decline to continue coverage during the administrative appeal.</p>
	<p>Policyholder Signature: _____ Date: _____</p>

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>
	<p> </p>

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: _____			

March 2019

Policyholder Termination of Coverage Form

Account Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice

Current Coverage Code: Indicate the Code of Coverage under which the employee was last covered.

HI01 PEIA PPB Plan A

HI02 PEIA PPB Plan B

HI03 PEIA PPB Plan C

H104 PEIA PPB Plan D

HMHP - A The Health Plan HMO Plan A

HMHP - B The Health Plan HMO Plan B

LB01 Life Insurance Only

Date Off Payroll: The last day the employee is on payroll.

Effective Date of Termination: This date should be the last day of the calendar month in which the employee's coverage ends. If an employee went off payroll January 1st, the effective date of termination would be January 31st. In the event an employee's last paycheck would not cover the PEIA health premium, and the employee chooses not to pay the premium, please indicate the last month for which the employee paid premiums. In the case where the dates are not within the same month, please provide details in the "other please explain" section.

Authorized Signature: Your signature as the Benefit Coordinator.

Agency Authorized Signature: If the Policyholder is unavailable to sign the Termination form, PEIA requires a second authorized signature and title to confirm termination of the employee.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder

Retirement Health Benefits and Basic Life Enrollment Form

State of West Virginia Public Employee Insurance Agency
Retiree Health and Basic Life Insurance Enrollment Form

Retiree
BL/Health

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Please read and follow the instructions included with this form when completing. Use this form to enroll for health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. This is a two-page form. You must submit both pages for your enrollment to be valid. Incomplete forms will be returned and may delay your enrollment. Complete all sections of the form except the last "Agency" portion. Return the completed forms to your HR department.

Retiree Information	Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
	Mailing Address	County of Residence
	City State Zip	Medicare ID Number (HIC)
	Physical Address	Home Telephone ()
	City State Zip	Sex (Circle one) M F
	Provide the date when you were or will be Medicare Eligible. Please also Provide a copy of your Medicare ID card now or when you are Medicare eligible.	Date of Birth (mm/dd/yy)
Provide the name of your last employer and your last day worked		

Dependent Information	Complete the following information ONLY for dependents to be covered under your plan.						
	Legal Name (Last, First, MI, Generation)	Address (if different from above)	Relationship	Sex	Birth Date	Social Security Number	Other Health Insurance (Plan Name)

Coverage	<p>Coverage Selection (Select One) I am enrolling for:</p> <p><input type="checkbox"/> Policyholder Only Health and Basic Life Print the name of the plan you choose here: _____</p> <p><input type="checkbox"/> Family Health and Basic Life Print the name of the plan you choose here: _____</p> <p><input type="checkbox"/> Basic Life Insurance Only (No Health Benefits)</p> <p><input type="checkbox"/> Basic Life Insurance Only (Health Benefits under spouse's PEIA plan)</p> <p><input type="checkbox"/> Health Insurance Only. (No Life Insurance Benefits) Print the name of the plan you choose here: _____</p>	<p>Earned Extended Benefits Sick and/or Annual leave and Faculty Credits I choose to use my credits to:</p> <p><input type="checkbox"/> Extend my employer-paid insurance coverage. Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining accrued leave.</p> <p><input type="checkbox"/> Increase my annuity amount. (Complete proper forms from CPRB)</p> <p>Please be aware that if you submit conflicting documents regarding the use of your leave credits, the document you file with the CPRB will take precedence.</p>
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This form is continued on page 2. You must complete and return both pages of the form for it to be valid.

**State of West Virginia Public Employee Insurance Agency
Retiree Health and Basic Life Insurance Enrollment Form**

Retiree
BL/Health

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Please read and follow the instructions included with this form when completing. Use this form to enroll for health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. This is a two-page form. You must submit both pages for your enrollment to be valid. Incomplete forms will be returned and may delay your enrollment. Complete all sections of the form except the last "Agency" portion. Return the completed forms to your HR department.

Beneficiary(s)	PEIA no longer stores Beneficiary information. Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.
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Affidavits	<p>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.</p> <p>Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last (6) months</p>
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Acceptance	<p><input type="checkbox"/> I hereby accept the group coverage I have indicated above. 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. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, all of medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.</p> <p><input type="checkbox"/> I do not wish to participate in ANY PEIA Health Coverage or Basic Life Coverage. I decline to participate in ANY PEIA Coverage at this time.</p> <p>Signature: _____ Date: _____</p>
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Agency	<table border="1"> <tr> <td>Agency Name</td> <td>Agency Account Number</td> <td>Hire Date</td> </tr> <tr> <td>Last date of active Employment</td> <td>Effective Date of Retirement</td> <td>Effective date of Retiree Insurance Coverage</td> </tr> <tr> <td colspan="3">Number of Days of accrued sick and annual leave for which the employee was not paid when employment ceased.</td> </tr> <tr> <td colspan="3">Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 month family coverage) Partial months are not allowed.</td> </tr> <tr> <td colspan="3">Total WV State Government credited years of service:</td> </tr> <tr> <td colspan="3">Higher Education Faculty Only: Total years of extended coverage in months: 3 and 1/3 years = 1 year of single coverage; 5 years' service = 1 year family coverage</td> </tr> <tr> <td colspan="3">Member Retirement from: <input type="checkbox"/> TIAA-CREF <input type="checkbox"/> TRS <input type="checkbox"/> TDC <input type="checkbox"/> PERS <input type="checkbox"/> TROOPERS</td> </tr> <tr> <td colspan="3">I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee meets the minimum eligibility requirements for the Public Employee Insurance Plan.</td> </tr> <tr> <td colspan="2">Authorized Signature: _____</td> <td>Date: _____</td> </tr> </table>	Agency Name	Agency Account Number	Hire Date	Last date of active Employment	Effective Date of Retirement	Effective date of Retiree Insurance Coverage	Number of Days of accrued sick and annual leave for which the employee was not paid when employment ceased.			Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 month family coverage) Partial months are not allowed.			Total WV State Government credited years of service:			Higher Education Faculty Only: Total years of extended coverage in months: 3 and 1/3 years = 1 year of single coverage; 5 years' service = 1 year family coverage			Member Retirement from: <input type="checkbox"/> TIAA-CREF <input type="checkbox"/> TRS <input type="checkbox"/> TDC <input type="checkbox"/> PERS <input type="checkbox"/> TROOPERS			I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee meets the minimum eligibility requirements for the Public Employee Insurance Plan.			Authorized Signature: _____		Date: _____
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**State of West Virginia Public Employee Insurance Agency
Retiree Health and Basic Life Insurance Enrollment Form**

Retiree BL/Health

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Please read and follow the instructions included with this form when completing. Use this form to enroll for health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. This is a two-page form. You must submit both pages for your enrollment to be valid. Incomplete forms will be returned and may delay your enrollment. Complete all sections of the form except the last "Agency" portion. Return the completed forms to your HR department.

Beneficiary(s)	<p>PEIA no longer stores Beneficiary information. Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.</p>
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Affidavits	<p>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.</p> <p>Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last (6) months</p>
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Acceptance	<p><input type="checkbox"/> I hereby accept the group coverage I have indicated above. 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. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, all of medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.</p> <p><input type="checkbox"/> I do not wish to participate in ANY PEIA Health Coverage or Basic Life Coverage. I decline to participate in ANY PEIA Coverage at this time.</p> <p>Signature: _____ Date: _____</p>
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Retirement Health Benefits and Basic Life Enrollment Form

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

Retiree
BL/Health

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Retirement Health Benefits and Basic Life Insurance Enrollment Form Instructions

Retiree: Complete all demographic information. Use your full **LEGAL** name. The 'Generation' area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III etc.

The Medicare ID Number can be found on your red, white, and blue Medicare card. The number is required for continued coverage when you reach Medicare age. If you are not yet eligible for Medicare, please send PEIA a copy of your Medicare card when you enroll for Medicare coverage.

PEIA needs information about Medicare coverage for you. Your premium decreases when you are retired and have Medicare.

Please provide the date when you were or will become eligible for Medicare. **When you become eligible for Medicare it is important that you enroll for both Medicare parts A and B.** Please see your summary plan description for more information.

PEIA needs information about your last employer prior to retirement and the last day worked (or will work) for that employer.

Dependent Information: Fill in any dependents that are to be covered under your health insurance plan. Please complete each box and if they are Medicare eligible, we will need a copy of their Medicare card. Please see the documentation chart in the Summary Plan Description to know what documentation is needed for proof of legal dependency for any dependents you may be adding.

Basic Life Beneficiary(s): PEIA no longer stores Beneficiary information. Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are to continue your health care coverage into retirement, you must remain in the health care plan you were in as an active employee through the end of the plan year (June30), unless you were in a managed care plan and will be Medicare eligible when you retire. Please be sure to fully specify the plan you want, including the plan name and any option, such as PEIA PPB Plan A or the Health Plan Plan B. For life insurance, on this form you can continue your Basic Life insurance. If you wish to continue Optional and/or dependent coverage, you must complete the Retiree Optional Life Insurance form.

Earned Extended Benefits: If you have sick and/or annual leave credits, you must specify how you want to use those credits. You may use them to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. For details, please see your Summary Plan Description. If you were hired after July 1, 2001, you cannot use sick/annual leave credits to extend employer-paid insurance coverage.

June 2022 1

Retirement Health Benefits and Basic Life Enrollment Form

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

Retiree BL/Health

Complete this form to enroll for Health and/or Basic Life coverage. Complete all sections of the form except "AGENCY"

Affidavit: PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discount.

Acceptance: When you have made your selections on this form, you must sign and date the "Acceptance" box and sign and date the bottom of the acceptance box. If you do not wish to enroll for health or life insurance coverage as a retiree, you must mark the appropriate "Declination" box and sign and date below it.

What next: When your form is completed to this point, please return it to eh Benefit Coordinator at your place of employment. Your Benefit Coordinator in your HR department will complete the agency portion of the form and submit it for processing.

Retirement Health Benefits and Basic Life Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Agency Account Number: Your 9-digit number found on the monthly billing invoice

Hire Date: Enter the date in month, day and year policyholder was hired.

Last date of Active Employment: Date employee was last actively on payroll

Effective Date of Retirement: Date the employee retires

Effective Date of Retiree Insurance Coverage: First day of the month following the date of retirement

Number of days accrued, sick and annual: Enter the total number of days to be used towards payment of premiums.

Number of Months earned extended coverage: Enter the total number of months earned for coverage of premiums. 2 days = 1 month of single coverage and 3 days = 1 month of family coverage. Partial months are not allowed.

WV State Credited years of Service: Enter the correct number of years without lapse in service.

Higher Ed years of extended coverage: Enter the correct number of months of extended coverage. 3 and 1/3 years = 1 year of single coverage and 5 years of service = 1 year of family coverage

Member Retirement from: Mark the correct box if any apply.

Authorized Signature: Your signature as the Benefit Coordinator

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Retirement Optional/Dependent Life Enrollment Form

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	Home Telephone
	City State Zip	()
	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.

Revised June 2022

Retirement Optional/Dependent Life Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Agency Account Number: Your 9-digit number found on the monthly billing invoice

Hire Date: Enter the date in month, day and year policyholder was hired.

Last date of Active Employment: Date employee was last actively on payroll

Effective Date of Retirement: Date the employee retires

Effective Date of Retiree Insurance Coverage: First day of the month following the date of retirement

OPT Plan: Use the option code below based on the plan chosen by the employee.

Active Employee Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	300
Plan IV	400
Plan V	500
Plan VI	600
Plan VII	650
Plan VIII	700
Plan IX	750
Plan X	800

If an employee chooses more than \$100,000 of coverage, he or she will be required to provide Evidence of Insurability. Please see the Life section of the BCRM for further details.

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400
5	500

Please note that if documentation is required for a dependent and cannot be submitted with the Optional and Dependent Life Insurance Enrollment form, the form on page 15 should accompany submission of the documentation to PEIA.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Surviving Dependent Enrollment Form

State of West Virginia Public Employees Insurance Agency Surviving Dependent Enrollment Form

Complete this form to enroll for health benefits as a surviving dependent. Mail completed form to PEIA, 601 57th St SE, Suite 2, Charleston, WV 25304

Survivor Information

Full Legal Name: (Last)	(First)	(MI)	Suffix (jr, Sr, III)	Social Security Number (SSN)
Physical Address: (street address, city, state and zip code)				Date of birth (mm/dd/yyyy)
Mailing Address (if different from above)				Phone Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	County of Residence			Date you were/will be entitled to Medicare
Deceased Policyholder's Name		Social Security Number		Date of Death
If you do not wish to participate in PEIA coverage, check the box, sign and return this form to the address above.				
<input type="checkbox"/> I decline to participate in any PEIA coverage. Surviving Dependent's Signature:				Date:

Family Information

Please list dependents to be enrolled in addition to the survivor above. Dependents must have been covered at the time of the policyholder's death to be eligible for coverage. Dependent children may be covered until age 26.

Full Legal Name (last, first MI, suffix)	Address (if different from above)	Relationship	Sex	Date of Birth	SSN

Coverage Selection If you are continuing coverage upon the death of the policyholder, you will stay in your current plan until the next open enrollment. If you are a survivor enrolling after a lapse in coverage, please choose a plan below.

<p>Choose your coverage</p> <p><input type="checkbox"/> Single Survivor's Health Coverage</p> <p><input type="checkbox"/> Family Survivor's Health Coverage</p>	<p>Non-Medicare Survivors – Please choose your plan.</p> <p><input type="checkbox"/> PEIA PFB Plan A <input type="checkbox"/> The Health Plan HMO Plan A</p> <p><input type="checkbox"/> PEIA PFB Plan B <input type="checkbox"/> The Health Plan HMO Plan B</p> <p><input type="checkbox"/> The Health Plan PPO Plan C</p> <p>Medicare Survivors – Please choose a plan:</p> <p><input type="checkbox"/> Humana/PEIA Plan 1 <input type="checkbox"/> Humana/PEIA Plan 2</p>
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Tobacco Affidavit

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: Surviving Spouse Dependent child(ren) No Tobacco Users within the last six (6) months

Acceptance

I hereby accept the group coverage I have indicated above. 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. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations. **I understand that upon remarriage, I will no longer be eligible for Survivor coverage and it is my responsibility to report that change to PEIA.**

Surviving Dependent's Signature: _____ Date: _____

This form is not specifically for use by Benefit Coordinators and does not require the Benefit Coordinator's signature. We are including it in this book for your convenience and reference.

Authorization to Remove WCC/BC



601 57th Street SE
Suite 2
Charleston, WV 25304
888-680-7342
peia.help@wv.gov
www.peia.wv.gov

AUTHORIZATION TO REMOVE BENEFIT COORDINATOR/WEB CONTRIBUTIONS COORDINATOR

Please remove the following individual as an active PEIA:

- Benefit Coordinator
- Web Contributions Coordinator

Employee Name: _____

Employee E-Mail Address: _____

Agency Name: _____

Agency Account Number: _____

Effective Date of Removal: _____

Authorization to Remove WCC/BC

It is important to *immediately* remove access of previous WCCs and BCs when they leave your agency.

Mark appropriate circles: Mark which roles from which they need access to be removed.

Employee Name: Enter the employee's name

Employee Email Address: Enter the employee's email address

Agency Name: Enter the name of the Agency

Effective Date of Removal: Enter the effective date of removal from the role(s).

Agency Account Number: Enter your 9-digit number found on the monthly billing invoice.

Authorized By: Write your printed name.

Title: Enter your title.

Telephone Number: Enter your telephone number at your agency.

Signature: Sign your signature.

Date: The date you sign the form. Forms should be signed immediately and emailed or faxed to PEIA.