PEIA
PUBLIC EMPLOYEES INSURANCE AGENCY

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PEIA Medicare Retiree Open Enrollment Form

Utilize this form to execute health enrollment modifications during the PEIA Medicare Retiree Open Enrollment period. Alternatively, you may submit your modifications electronically via the PEIA ACCESS Portal online at peia.wv.gov.

Section 1: Policyholder Information

Name: _____

SSN: _____ DOB:_____

Address: _____

_____

Email: _____

Phone: _____

Section 2: 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:

☐ Policyholder

☐ Dependent (spouse and/or children)

☐ No Tobacco Users within the last (6) months

Section 3: Health Plan Selection

Use this section to select your PEIA health plan or to decline health coverage. Please, indicate your selection clearly by checking only one box in the fields below:

☐ **Humana Plan 1** [mirrors traditional benefits]	☐ **Humana Plan 2** [Offers lower premiums with higher out-of-pocket costs]	☐ **Decline Health Coverage**

Section 4: Dependent Changes

Use this section to add or remove dependents in the boxes below. Indicate Add or Remove. Documentation required for all additions.

(Circle One)	Dependent Legal Name	Relationship	DOB	SSN	Medicare ID
Add Remove					
Add Remove					

Section 5: Consent and Signature

☐ 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. I understand that this change is binding through the end of the plan year, unless there is a qualifying event which would allow me to make a change.

Signature: _____ Date: _____