Comprehensive Care Partnership (CCP) Program
Enrollment Form

Policyholder Name: _____ Address: _____

PEIA ID Number: _____ Daytime Phone: _____

Insurance effective date:_____ E-mail: _____

To enroll online, go to **www.wvpeia.com** and click on the green "**Manage My Benefits**" button in the upper right corner, register on the site or use your existing credentials to log-in and choose your CCP. If you do not have online access, you may complete this form.

Covered Individuals – PPB Plan A, B & D (Only individuals listed below will be enrolled)	**Date of Birth**	**Relationship to Policyholder (Self, Spouse, Child)**	**CCP Location** **Include Name of Facility and Provider ID Number**
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____

PEIA's CCP Program requires the member's active participation and program compliance.

I agree that the above-listed persons enrolled on my PEIA PPB Plan coverage will participate in the CCP program at the above-listed health care provider. I agree that I (we) will abide by the rules, policies and restrictions of the CCP program (the member agreement is available on-line or by calling customer service). I understand that if I (we) do not abide by the rules, policies and restrictions of the CCP program, I (we) may be dis-enrolled from the program by the CCP.

Policyholder signature: _____ Date: _____

Please return this form to: **Public Employees Insurance Agency, Attn: CCP, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345 or Fax to 1-877-233-4295.** Coverage in the CCP will be effective on the first day of the month following receipt of your enrollment form, if received before the 25th of the month.