

**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 | |
| | Home Telephone () | | Work Telephone () | |
| | City State Zip | | Sex (Circle one) M F | |
| | Physical Address | | Date of Birth (mm/dd/yy) | |

****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 65 | \$5,000 | \$10,000 | \$20,000 | \$30,000 | \$40,000 | \$50,000 | \$60,000 | \$75,000 | \$80,000 |
| Age 65 to 69 | 3,250 | 6,500 | 13,000 | 19,500 | 26,000 | 32,500 | 39,000 | 48,750 | 52,000 |
| Age 70 and | 2,250 | 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 65 | \$100,000 | \$150,000 | \$200,000 | \$250,000 | \$300,000 | \$350,000 | \$400,000 | \$450,000 | \$500,000 |
| Age 65 to 69 | 65,000 | 97,500 | 130,000 | 162,500 | 195,000 | 227,500 | 260,000 | 292,500 | 325,000 |
| Age 70 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

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 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: |