TERM

State of West Virginia Public Employee Insurance Agency
Policyholder Termination of Coverage Form

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 ( )
City State Zip	Work Telephone ( )
Physical Address	Sex (Circle one) M F
City State Zip	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

***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.

- ☐ Resignation (B.C: if transferring to another PEIA insured agency, please use the online transfer function in Manage My Benefits)
- ☐ Terminated for Misconduct (If an Administrative appeal is being instituted, please complete the *Administrative Appeal* section of this form)
- ☐ Terminated Involuntarily or by reduction in work force.
  I ☐ do ☐ do not accept the (3) additional months of extended benefits.
- ☐ Voluntarily cancel all coverage. Re-enrollment restrictions may apply***
  (To cancel health insurance only, use a Change in Status form)
- ☐ Retirement
- ☐ Cancellation of Employee Basic Life insurance***
- ☐ Cancellation of Employee Optional Life insurance***
- ☐ Cancellation of Dependent Optional Life Insurance***
- ☐ Deceased (Please enter the date of death) _____
- ☐ Surviving Dependent Remarriage (Please enter the date of Marriage) _____
- ☐ Termination (If policyholder is unavailable for signature, Form must be signed the BC and by another staff member of the agency)
- ☐ Affordable Care Act
- ☐ Other (Please explain)_____

Required Policyholder Signature: Date:

Administrative Appeal

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:

- ☐ 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.
- ☐ I decline to continue coverage during the administrative appeal.

Policyholder Signature: Date:

COBRA

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 elcect continuation of coverage. COBRA premiums include bothe the employer and employee share of the premium, as well as an adminstrative 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.

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: _____