

• Existing benefits not indicated on this form will

continue as currently enrolled.

STATE OF WEST VIRGINIA EMPLOYEE ENROLLMENT FORM



July 1, 2024 - June 30, 2025

•	INSTRUCTIONS: DURING OPEN ENROLLMENT, R	ETURN COMPLETED FORM TO YOUR BENEFITS COORDINAT	OR NO LATER THAN MAY 15, 2024
	WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?	HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:	CHANGE IN ELECTION • Include supporting documentation.
	New participants who want to enroll for the first time. Employees who want to add, change or cancel any benefits.	IMPORTANT: If you want to add, change or cancel coverage, you must check the box beside the appropriate benefit in Section 3. Indicate coverage levels and any other pertinent	Must be requested within the month of and two months following your status changing event.

IMPORTANT: If you want to add, change or cancel coverage, you must check the box beside the appropriate benefit in Section 3. Indicate coverage levels and any other pertinent information. If you select dependent coverage for any benefit, you must provide dependent information in Section 4. Include supporting documentation. Must be requested within the month of and two months follow your status changing event. List all eligible dependents you want covered.

SSN#			,	E-M	AIL			Open Er	nrollment	Ne	ew Hire	
								Transfer		Ch	ange in Status	
LAST NAM	1E						FIRST NAME				MI	
HOME AD	DRESS [STREE	ET]				CITY	STATE	ZIP		HOME PHON	L IE	
BIRTH DAT	TE		MA	ALE	MARRIED	DATE EMPLOYED	EFFECTIVE DA	TE		CELL PHONE		
			FE	MALE	SINGLE							
			MOL	JNT	AINEER	FLEXIBLE BENEFIT	rs (PAI	D BY E	MPLOY	EES)		
Keep	ADD	CHANGE	CANCEL				ENEFITS		_			COST PER
	e COVERAGE				If you sele	ect Employee & DEPENDENT coverage		nplete the de	ependent inform	ation in Sectio	n 4.	PAY PERIOD
						POST-	TAX BENE	FITS				
				HOS	PITAL INDE	EMNITY INSURANCE	☐ Emp	oloyee Only		Employee & S	pouse	
							Emp	ployee & Child	dren	Employee & F	amily	
				0 D I I			Emp	Employee Only: Benefit amount			_	
				CRITICAL ILLNESS INSURANCE Refer back to your benefit guide for rates and rules.			☐ Spc	Spouse Only: Benefit amount				
							Chil	dren Only: Ber	nefit amount			
$ \Box$		Ιп		ACC	IDENT INSU	URANCE	☐ Emp	oloyee Only		Employee & S	pouse	
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	1	1				PRET	AX BENE	FITS				
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$ \Box$				HFΔ	RING SERV	/ICE PLAN	☐ Emp	oloyee Only		Employee & S	pouse	
							Emp	ployee & Child	dren	Employee & F	amily	
				HEA	LTH CARE I	FLEXIBLE SPENDING ACCOU	NT All Claims M	lust Be Submit	ted By October 31	, 2025.		
$\mid \sqcap \mid$		Ιп				ARE FLEXIBLE SPENDING AC			Submitted By Octo	ober 31, 2025.		
					Married, Filing Se	eparately Married, Filing Jointly S	1		age type:			
				HEALTH SAVIN				Select your HSA coverage type: Individual (\$4,150 maximum for PY 2025)				
						A Plan C. Contribution Is Per Pay Period. dealth Care Flexible Spending Account.	I —		aximum for PY 20			
								or outen up	, (additional maxii	11411 \$1,000)		
				LONG-TERM DISABILITY INCOME PLAN				Employee Only 50% Coverage Level 60% Coverage			_	
							Grandfath	nered 70% cover	rage level Cui	rently enrolled o	nly	
				SHO	RT-TERM D	DISABILITY INCOME PLAN Em	ployee Only				_	
				LIMI	TED HEALT	TH CARE FSA Must be enrolled in HSA						
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STATE OF WEST VIRGINIA EMPLOYEE ENROLLMENT FORM



July 1, 2024 - June 30, 2025

USE A							CHEC	COVERAG	E SELECTED		
DEPENDENT NAME	RELATIONSHIP	MALE/ FEMALE	BIRTH DATE	SOCIAL SECURITY #	DENTAL	VISION	HEARING	LEGAL	ACCIDENT INSURANCE	CRITICAL ILLNESS	HOSP
	Spouse										
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ENROLLMENT FORMS SHOULD BE MAILED TO: FBMC, PO BOX 1878, TALLAHASSEE, FL 32302-1878 DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY MAY 15, 2024.