

State of West Virginia ★ Public Employees Insurance Agency

Health Benefits Enrollment Form

HEALTH

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY."

EMPLOYEE	Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)			Social Security Number																																											
	Street Address			County of Residence		Home Phone ()																																									
	City		State	Zip	Job Title	Work Phone ()																																									
	Sex (Circle One) M F	Date of Birth (mm/dd/yyyy)		Other Insurance (Plan Name) If Any																																											
	Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES <input type="checkbox"/> NO <input type="checkbox"/>																																														
If you do not wish to participate in any PEIA health coverage, please sign this box and return this form to your benefit coordinator. I decline to participate in the health coverage. Signature: _____ Date: _____																																															
Is spouse currently insured by PEIA as a policyholder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter spouse's Social Security Number: _____																																															
Please complete the following information for all dependents who will be covered under your plan:																																															
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name Last, First, MI, Generation)</th> <th style="width: 20%;">Address (If different from above)</th> <th style="width: 5%;">Relationship (Circle One)</th> <th style="width: 5%;">Sex/ Category</th> <th style="width: 10%;">Birth Date</th> <th style="width: 10%;">Social Security Number</th> <th style="width: 20%;">Other Insurance (Plan Name)</th> </tr> </thead> <tbody> <tr> <td>-----</td> <td>-----</td> <td>SP CH</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>-----</td> <td>-----</td> <td>SP CH</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>-----</td> <td>-----</td> <td>SP CH</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>-----</td> <td>-----</td> <td>SP CH</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>-----</td> <td>-----</td> <td>SP CH</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Name Last, First, MI, Generation)	Address (If different from above)	Relationship (Circle One)	Sex/ Category	Birth Date	Social Security Number	Other Insurance (Plan Name)	-----	-----	SP CH					-----	-----	SP CH					-----	-----	SP CH					-----	-----	SP CH					-----	-----	SP CH				
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<p>CATEGORY for Dependent Child(ren): Relationship Code 1. Child (biological or adopted) 2. Step-child 3. Grandchild 4. Court-Ordered Dependent Child 5. Student (age 19-25) 6. Other In dependent column titled "Sex/Category", please include both gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). <i>If adding a dependent child other than your biological or adopted child, documentation is required showing legal guardianship of the child.</i></p>																																															
<p>COVERAGE SELECTION (Select One) I am enrolling for:</p> <table style="width:100%;"> <tr> <td style="width: 30%;"> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">1</td><td>Employee Only</td></tr> <tr><td style="text-align: center;">2</td><td>Employee/Child(ren) Only</td></tr> <tr><td style="text-align: center;">3</td><td>Family</td></tr> <tr><td style="text-align: center;">4</td><td>Family with Employee Spouse</td></tr> </table> </td> <td style="width: 40%;"> Please indicate the plan in which you are enrolling by checking the box beside the plan option you choose: </td> <td style="width: 30%;"> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">4</td><td>The Health Plan HMO Plan A</td></tr> <tr><td style="text-align: center;">5</td><td>The Health Plan HMO Plan B</td></tr> </table> </td> </tr> <tr> <td></td> <td> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">1</td><td>PEIA PPB Plan A</td></tr> <tr><td style="text-align: center;">2</td><td>PEIA PPB Plan B</td></tr> <tr><td style="text-align: center;">3</td><td>PEIA PPB Plan C</td></tr> </table> </td> <td></td> </tr> </table>						<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">1</td><td>Employee Only</td></tr> <tr><td style="text-align: center;">2</td><td>Employee/Child(ren) Only</td></tr> <tr><td style="text-align: center;">3</td><td>Family</td></tr> <tr><td style="text-align: center;">4</td><td>Family with Employee Spouse</td></tr> </table>	1	Employee Only	2	Employee/Child(ren) Only	3	Family	4	Family with Employee Spouse	Please indicate the plan in which you are enrolling by checking the box beside the plan option you choose:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">4</td><td>The Health Plan HMO Plan A</td></tr> <tr><td style="text-align: center;">5</td><td>The Health Plan HMO Plan B</td></tr> </table>	4	The Health Plan HMO Plan A	5	The Health Plan HMO Plan B		<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">1</td><td>PEIA PPB Plan A</td></tr> <tr><td style="text-align: center;">2</td><td>PEIA PPB Plan B</td></tr> <tr><td style="text-align: center;">3</td><td>PEIA PPB Plan C</td></tr> </table>	1	PEIA PPB Plan A	2	PEIA PPB Plan B	3	PEIA PPB Plan C																			
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<p>AFFIDAVITS</p> <p>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 WVPEIA or its agents have access to my medical records to check my tobacco use status.</p> <p>Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last six (6) months</p> <p>Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form.</p> <p><input type="checkbox"/> By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.</p>																																															
<p>ACCEPTANCE</p> <p>I hereby accept the group coverage I have indicated above. I understand that the PEIA may change the types 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 that 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, of all 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.</p> <p>Employee's Signature: _____ Date: _____</p>																																															
To Be Completed By The Employer:																																															
AGENCY																																															
Agency Name		Account Number		Date of Employment																																											
Hours Worked Weekly	Effective Date of Coverage	Index Code	Region	Coverage Code																																											
I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employees Insurance Plan.																																															
Authorized Signature			Date																																												

Please send only the original to PEIA

Revised December 15, 2010

Health Benefits Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Date of Employment: Date Employee was hired or the date he or she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms to elect the coverage). Remember that the employee must be actively at work for coverage to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Index Code: Choose the code from the appropriate chart below to reflects the employee's annual salary.

For State Agencies, Colleges, Universities and County Boards of Education		
For the PEIA PPB Plan A and ALL managed care coverages		
	Salary	
Index Code	From	To
01	\$ 0	\$ 20,000
02	\$ 20,001	\$ 30,000
03	\$ 30,001	\$ 36,000
04	\$ 36,001	\$ 42,000
05	\$ 42,001	\$ 50,000
06	\$ 50,001	\$ 62,500
07	\$ 62,501	\$ 75,000
08	\$ 75,001	\$100,000
09	\$100,001	\$125,000
10	\$125,001	and over
04	Legislature	

PEIA PPB Plan B		
	Salary	
Index Code	From	To
01	\$ 0	\$ 20,000
02	\$ 20,001	\$ 30,000
03	\$ 30,001	\$ 36,000
04	\$ 36,001	\$ 42,000
05	\$ 42,001	\$ 50,000
06	\$ 50,001	\$ 62,500
07	\$ 62,501	\$ 75,000
08	\$ 75,001	\$100,000
09	\$100,001	\$125,000
10	\$125,001	and over
04	Legislature	

For Non-State Agencies	
Plan	Option Code
PEIA PPB Plan A	004
PEIA PPB Plan B	010

Region: Leave blank. No longer used.

Coverage Code: Please use one of the codes below to indicate which plan the policyholder chose:

HI01	PEIA PPB Plan A
HI02	PEIA PPB Plan B
HI03	PEIA PPB Plan C
HMHP - A	Health Plan HMO Plan A
HMHP - B	Health Plan HMO Plan B

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

- P = Policyholder Only
- F = Policyholder, Spouse and Children
- C = Policyholder and Children Only
- S = Policyholder and Spouse Only (generates same premium as F)

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. If the addition of health coverage creates an ESPS situation, PEIA needs to be aware of the IDX change if applicable so that it may be made at time of entry into the PEIA system. PEIA does not have access to salaries.

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-F**.

Please note that if documentation is required for a dependent and cannot be submitted with the enrollment application, **the form on page 9 should accompany submission of the documentation to PEIA.**

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

State of West Virginia ★ Public Employees Insurance Agency
Basic Life Insurance Enrollment Form

**BASIC
LIFE**

Complete this form to enroll for PEIA basic life insurance coverage. Complete all sections of the form except the last section, "AGENCY", and return it to your benefit coordinator.

EMPLOYEE	Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)		Social Security Number
	Street Address		County of Residence Home Phone ()
	City	State Zip	Job Title Work Phone ()
	Sex (Circle One) M F	Date of Birth (mm/dd/yyyy)	If you do not wish to participate in PEIA coverage, please sign this box and return this form to your benefit coordinator. I decline to participate in any PEIA coverage. Signature: Date:

BENEFICIARY	Please designate the beneficiary(ies) of this basic term life insurance policy in the space provided below. The life insurance amount will be distributed equally among all designated beneficiaries unless otherwise indicated. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no beneficiary survives the employee, payment will be made in accordance with the terms of the policy. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe".				
	Beneficiary Name (Last, First, MI, Generation)	Beneficiary Address (Street, City, State, Zip)	Social Security #	Relationship To Insured	Distribution % <i>Total must equal 100%</i>
	-----	-----	-----	-----	-----
	-----	-----	-----	-----	-----

COVERAGE	Decreasing Term Benefit For Active Employees	
	The Basic Life Insurance offered by PEIA is decreasing term coverage, which means that the amount of life insurance decreases as you age. Here are the policy values for Active employees:	
	Employee under age 65	\$10,000
	Employee Age 65 but under 70	\$6,500
	Employee Age 70 and over	\$5,000

AFFIDAVIT	Tobacco Affidavit
	Please mark which members of the family use tobacco and sign the acceptance box below. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your PEIA PPB Plan health coverage (if any) and optional life insurance premiums. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status. Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last six (6) months

ACCEPTANCE	I hereby accept the basic life insurance. I understand that the PEIA may change the types 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 that those who provide false information may be prosecuted.
	Employee Signature: _____ Date: _____

To Be Completed By The Employer:

AGENCY	Agency Name		Account Number	Date of Employment
	Hours Worked Weekly	Effective Date of Coverage	Index Code	Region Coverage Code
	I hereby certify that this information is true and this applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan. Authorized Signature: _____ Date: _____			

WHITE - PEIA CANARY - Payroll Location PINK - Employee

Revised July 2004

Basic Life Insurance Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Date of Employment: Date Employee was hired or the date he or she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms and returns it to you to elect the coverage), if it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application; PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. We will contact you when the medical underwriting decision has been made. Remember that the employee must be actively at work for coverage to begin. If the employee is not actively at work due to illness or injury on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Index Code: Index Code: Choose the code from the appropriate chart on Page 2 that reflects the employee's annual salary.

Region: Not necessary on the Basic Life form.

Coverage Code: Mark with code **LB01** for basic life.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

**State of West Virginia • Public Employees Insurance Agency
Change-In-Status Form**

**Change in
Status**

Complete this form to change the status of your coverage. Complete all sections as appropriate except the Employer Information on page 2 and return the form to your benefit coordinator.

Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Street Address	Check if New Address <input type="checkbox"/>		County of Residence	Home Phone ()
City	State	Zip	Job Title	Work Phone ()
Do you participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES <input type="checkbox"/> NO <input type="checkbox"/>				

CHANGE TYPE Please indicate the status change you are making:

- 001 Change name listed above to: (Last) _____ (First) _____ (MI) _____
- 002 Transfer employee's premium billing from employer account # _____ to account # _____ within the same agency
- 003 Add Dependents to: (Mark your choice) Health Dependent Optional Life Insurance (check one) Plan 1 Plan 2 Plan 3 Plan 4
(Complete dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.)
- 004 Remove Dependents from: (Mark your choice and complete dependent information below) Health Dependent Optional Life Insurance
- 005 Change in health coverage:
From: (Plan Name) _____ To: (Plan Name) _____
- 006 Add Health Coverage: PEIA PPB Plan A PEIA PPB Plan B PEIA PPB Plan C Health Plan HMO Plan A Health Plan HMO Plan B
- 007 Drop Health Coverage. Keep life insurance ONLY. This terminates health coverage for policyholder and all dependents.
- 008 Tobacco Status Change.
- 009 Advance Directive/Living Will Affidavit Change.

Dependent Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)	Sex (Circle One)	Birth Date (mm/dd/yyyy)	Social Security Number
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		

Status Change Reason. Policyholder must provide documentation for every type of status change. See attached memo for details.

1	Marriage	5	Death of spouse or dependent	9	Ineligibility of dependent child due to his/her employer-sponsored coverage
2	Divorce	6	Beginning or end of spouse's employment	10	Change from full-time to part-time employment or vice versa for employee or spouse
3	Birth of Child	7	Significant change in health coverage due to spouse's employment	11	Open Enrollment
4	Adoption	8	Unpaid leave of absence by employee or spouse	12	Other (please specify): _____ _____

I certify that on ____/____/____ (date of event) I incurred the status change marked above, and I, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the event. I further understand that I am required to provide documentation of this event to the WV Public Employees Insurance Agency.

This form is continued on page 2. You must complete and return both pages of the form for it to be valid. Please continue.

**Change in Status Form
Page 2**

Policyholder's Last Name: _____ Last four digits of SSN: _____

COBRA

Under Federal COBRA law, PEIA must offer continued coverage to qualified policyholders or dependents under certain circumstances. If you qualify, you will be sent notification with the necessary applications by Wells Fargo, who administers COBRA for the PEIA. You will have a limited amount of time to elect continuation of coverage. If dependent's address is different than the policyholder's address, please provide the dependent's address here:

Dependent Name: _____

Street Address: _____

City, State, Zip _____

Premium Discount Affidavits

Tobacco Affidavit: Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your PEIA coverage uses tobacco, you will receive a premium discount on any PEIA PPB Plan health coverage and/or optional life insurance. I acknowledge by signing the Acceptance box below that WVPEIA 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 six (6) months

Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form in the Acceptance box below.

By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.

Acceptance

I hereby accept the changes to my group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the changes I have made may affect my contributions. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that 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, of all 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.

Employee's Signature: _____

Date: _____

Employer Information -- TO BE COMPLETED BY AGENCY BENEFIT COORDINATOR

Account Number

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Agency Name (optional): _____

Effective Date of Status Change

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Index Code

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I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: _____

Date: _____

Please submit only the original to PEIA

Revised January 12, 2012

Change - In - Status Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Index Code: Choose the code from the appropriate chart below to reflect the employee's annual salary.

For State Agencies, Colleges, Universities and County Boards of Education		
For the PEIA PPB Plans A & B and ALL managed care coverages		
Index Code	Salary	
	From	To
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06	\$ 50,001	\$ 62,500
07	\$ 62,501	\$ 75,000
08	\$ 75,001	\$100,000
09	\$100,001	\$125,000
10	\$125,001	and over
04	Legislature	

For Non-State Agencies	
Plan	Option Code
PEIA PPB Plan A	004
PEIA PPB Plan B	010

Coverage Code (old and new): Please use one of the codes below to indicate which plan the policyholder is moving from and which plan the policyholder is moving to:

HI01	PEIA PPB Plan A
HI02	PEIA PPB Plan B
HI03	PEIA PPB Plan C
HMHP - A	Health Plan HMO Plan A
HMHP - B	Health Plan HMO Plan B

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

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- F = Policyholder, Spouse and Children
- C = Policyholder and Children Only
- S = Policyholder and Spouse Only (generates same premium as F)

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. If the addition of health coverage creates an ESPS situation, PEIA needs to be aware of the IDX change if applicable so that it may be made at time of entry into the PEIA system. PEIA does not have access to salaries.

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-F**.

Effective Date of This Status Change: Typically this date is the 1st day of the following month the employee has signed to elect the change. For example, if the Change in Status is dated Jan 28, 2010, by the employee, the effective date would be 2-1-2010.

In the case of a newborn or adopted child, the effective date may be retroactive. For **newborns** added within the month of birth and the two following calendar months effective date of coverage is the date of the child's birth. For **adopted children** if added within the month of adoption or the following two calendar months, the effective date of coverage is retroactive to the date the child was placed in the home or the date the policyholder became financially responsible for the adopted child.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Remember that all changes require documentation, and no changes can be made outside Open Enrollment without a qualifying event. **If you cannot submit the documentation with the Change in Status form, the form on the following page should accompany submission of documentation to PEIA.**

**State of West Virginia
Public Employees Insurance Agency
Policyholder Termination Of Coverage Form**

TERM

Complete this form to terminate your health and/or optional life insurance coverage. Please complete all sections as appropriate except the last section ("AGENCY") and return to your benefit coordinator.

EMPLOYEE	Name (Last) (First) (MI) (Generation: Jr., Sr., etc.) Social Security Number
	Street Address County of Residence Home Phone ()
	City State Zip Job Title Work Phone ()
	Is spouse currently insured by PEIA as a policyholder? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide spouse's Social Security Number (SSN): _____

TERMINATION REASON	Check Appropriate Box:
	<input type="checkbox"/> 001 Resignation (If transferring to another PEIA-insured agency, please give agency name _____)
	<input type="checkbox"/> 002 Terminated for Misconduct (If an Administrative Appeal is being instituted, please complete the "ADMINISTRATIVE APPEAL" section of this form).
	<input type="checkbox"/> 003 Terminated involuntarily or by reduction in work force <input type="checkbox"/> I DO <input type="checkbox"/> I DO NOT accept the three (3) additional months of extended benefits
	<input type="checkbox"/> 004 Voluntarily cancel all coverage. Re-enrollment restrictions may apply.**** (To cancel health insurance only, use a change-in-status form.)
	<input type="checkbox"/> 005 Retirement
	<input type="checkbox"/> 006 Cancellation of Employee Optional Life Insurance ****
	<input type="checkbox"/> 007 Cancellation of Dependent Optional Life Insurance
	<input type="checkbox"/> 008 Deceased (Please enter date of death) _____
	<input type="checkbox"/> 009 Surviving dependent remarriage (Please enter date of marriage) _____
	<input type="checkbox"/> 010 Termination -- Policyholder unavailable for signature (for use by agency benefit coordinator only)
	<input type="checkbox"/> 011 Other (Please explain) _____

**** According to IRS regulations, IRS Section 125 Premium Conversion Plan participants cannot voluntarily terminate a benefit without a qualifying event. If you are a Section 125 participant and this action is being requested outside of the Section 125 open enrollment period, please state the qualifying event and attach documentation to support the event. Please refer to your Summary Plan Description for further details and a list of qualifying events.

Policyholder Signature: _____ Date: _____

ADMINISTRATIVE APPEAL	In the case of a termination for misconduct, you may have the right to an administrative appeal. If an administrative appeal is to be instituted, with your employer's approval, you may continue your coverage for 3 MONTHS after the end of the month in which you are removed from the payroll, as long as you 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:
	<input type="checkbox"/> 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. <input type="checkbox"/> 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 Acordia National, the company which administers COBRA for PEIA. You will have a limited amount of time to elect continuation of coverage.
	COBRA premiums include both the employer and employee share of the premium, as well as an administrative 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 Acordia National at 1-888-440-7342.

To Be Completed By The Employer:

AGENCY	Agency Name	Effective Date of Termination	Account Number	Date Off Payroll	Current Coverage Code
	I hereby certify that, to the best of my knowledge, the information contained herein is accurate.				
	Authorized Signature: _____			Date: _____	

WHITE - PEIA YELLOW - PEIA for MCO PINK - Payroll Location GOLDENROD - Employee *Revised July 2004*

Policyholder Termination of Coverage Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Effective Date of Termination: This date should be the last day of the calendar month in which the employee's coverage ends. If an employee went off payroll January 1st, the effective date of termination would be January 31st. In the event an employee's last paycheck would not cover the PEIA health premium, and the employee chooses not to pay the premium, please indicate the last month for which the employee paid premiums. In the case where the dates are not within the same month, please provide details in the "other please explain" section.

Date Off Payroll: The last day the employee is on payroll.

Current Coverage Code: Indicate the Code of Coverage under which the employee was last covered.

HI01	PEIA PPB Plan A
HI02	PEIA PPB Plan B
HI03	PEIA PPB Plan C
HMHP - A	Health Plan HMO Plan A
HMHP - B	Health Plan HMO Plan B
LB01	Life Insurance Only

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

**State of West Virginia
Public Employees Insurance Agency
Health Benefits and Life Insurance Change-In-Address Form**



Complete this form to advise PEIA of a change in address. Please complete all sections as appropriate except the last section, "AGENCY", and return to your payroll coordinator.

E M P L O Y E E	Name (Last) (First) (MI) (Generation)				Social Security Number		
	OLD ADDRESS Street		County of Residence		Home Phone ()		
	City State		Zip		Work Phone ()		
	Indicate Coverages That Are Currently Active <input type="checkbox"/> Health <input type="checkbox"/> Optional Life <input type="checkbox"/> Basic Life <input type="checkbox"/> Optional Dependent Life						

C H I L D R E P L A C E	NEW ADDRESS OF POLICYHOLDER Street		County of Residence		Home Phone ()	
	City State		Zip		Work Phone ()	
	Effective Date of New Address		Employee's Signature			

D E P E N D E N T	Name (Last, First, MI, Generation)	Address (If different from above)	Relationship (Circle One)	Sex/Category M/F	Birth Date (mm/dd/yy)	Social Security #	Effective Date of New Address
			SP CH				
			SP CH				
			SP CH				
			SP CH				
CATEGORY for Dependent Child(ren): 1. Child (biological or adopted) 3. Grandchild 5. Student (age 19-25) 2. Step-child 4. Court-Ordered Dependent Child 6. Other In dependent column titled "Sex/Category", please write (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.).							

To Be Completed By The Employer:

A G E N C Y	Agency Name		Agency Address (Include City, State and Zip Code)		Region
	Account Number	Authorized Signature:		Date:	

WHITE - PEIA YELLOW - Managed Care Plan PINK - Payroll Location GOLDENROD - Employee PEIA - 4005
Revised January 2004

Health Benefits and Life Insurance Change - In - Address Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Agency Address: Your agency address.

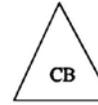
Region: No longer required on the Change in Address form.

Account Number: Your 9-digit agency account number as it appears on your billing.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

State of West Virginia
Public Employees Insurance Agency
Basic and/or Optional Life Insurance Change of Beneficiary Form



Complete this form to update or change the distribution of your insurance benefits.
Complete all sections of the form except the last section, "AGENCY".

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Name (Last)	(First)	(MI)	(Generation)	Social Security Number
Sex (Circle One)	Male	Female	Date of Birth (MM/DD/YY)	Work Phone ()
Street Address	City	State	Zip Code	Home Phone ()

Please choose one of the following:

Please change the beneficiary(s) of my **Basic Life Insurance**. Complete Section A below.

Please change the beneficiary(s) of my **Optional Life Insurance**. Complete Section B below.

Please change the beneficiary(s) of **both** my Basic and Optional Life Insurance. Complete Section A and Section B below.

If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary after his/her name. If no percentage is noted the death benefit will be paid in equal shares to the named beneficiaries who survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

SECTION A -- BASIC LIFE INSURANCE CHANGE OF BENEFICIARY
Please designate the beneficiary(s) of your basic life insurance coverage below. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe".

Beneficiary Name (Last, First, Middle Initial)	Relationship to the Insured	Address (Street Address, City, State, Zip Code)

SECTION B -- OPTIONAL LIFE INSURANCE CHANGE OF BENEFICIARY
Please designate the beneficiary(s) of your optional life insurance coverage below. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe".

Beneficiary Name (Last, First, Middle Initial)	Relationship to the Insured	Address (Street Address, City, State, Zip Code)

I wish to make the changes marked above. I understand that I may, at a future date, choose to change the above beneficiary(s) in accordance with policy provisions.

Employee's Signature _____ Date _____

Witness' Signature _____ Date _____

(MUST be a person other than a beneficiary.)

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Agency Name	Account Number
Coverage Code	Date of Employment
	Effective Date of Coverage
Authorized Signature:	Date:

WHITE - PEIA YELLOW - Payroll Location PINK - Enrollee PEIA - 0025 Revised August 1998

Basic and/or Optional Life Insurance Change of Beneficiary Form

You do not need to complete the Agency section of this form. All of the Employee information is required, but we no longer require the Benefit Coordinator to complete or sign this form.

**State of West Virginia
Public Employees Insurance Agency
Optional Life Insurance and Dependent Life Insurance Enrollment Form**

OPT

Complete this form to enroll for or increase optional and/or dependent life insurance coverage. Complete all sections of the form except the one titled "AGENCY," which must be completed by the benefit coordinator at your place of employment. Return the completed form to your benefit coordinator. Do not mail it to PEIA.

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Name (Last) (First) (M)		Social Security Number	
Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (MM/DD/YYYY)	
Street Address City State Zip Code		Work Phone () ()	
		Home Phone () ()	
<p>Optional Life Insurance - If you have enrolled in basic life insurance, you may choose to enroll for optional life and accidental death and dismemberment insurance for yourself. Your coverage is based on your selection and your age on the effective date of coverage. You must be actively at work on the date coverage becomes effective; otherwise coverage will be delayed until you are actively at work. Coverage of more than Plan X requires that you complete a Medical Information Form and be approved by the life insurance carrier. To enroll for coverage, check the box beside the amount of optional life insurance you desire:</p>			
Employee's Age	<input type="checkbox"/> Plan I	<input type="checkbox"/> Plan II	<input type="checkbox"/> Plan III
Under age 65	\$5,000	\$10,000	\$20,000
Age 65 to 69	3,250	6,500	13,000
Age 70 and above	2,250	4,500	9,000
	<input type="checkbox"/> Plan IV	<input type="checkbox"/> Plan V	<input type="checkbox"/> Plan VI
	\$30,000	\$40,000	\$50,000
	19,500	26,000	32,500
	13,500	18,000	22,500
	<input type="checkbox"/> Plan VII	<input type="checkbox"/> Plan VIII	<input type="checkbox"/> Plan IX
	\$60,000	\$75,000	\$80,000
	39,000	48,750	52,000
	27,000	33,750	36,000
Employee's Age	<input type="checkbox"/> Plan X	<input type="checkbox"/> Plan XI	<input type="checkbox"/> Plan XII
Under age 65	\$100,000	\$150,000	\$200,000
Age 65 to 69	65,000	97,500	130,000
Age 70 and above	45,000	67,500	90,000
	<input type="checkbox"/> Plan XIII	<input type="checkbox"/> Plan XIV	<input type="checkbox"/> Plan XV
	\$250,000	\$300,000	\$350,000
	162,500	195,000	227,500
	112,500	135,000	157,500
	<input type="checkbox"/> Plan XVI	<input type="checkbox"/> Plan XVII	<input type="checkbox"/> Plan XVIII
	\$400,000	\$450,000	\$500,000
	260,000	292,500	325,000
	180,000	202,500	225,000
Please designate the beneficiary(s) of your optional life insurance coverage below. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J.A. Doe." You may change your beneficiary at any time by filing a Change of Beneficiary form with PEIA.			
Beneficiary Name (Last, First, Middle Initial)		Relationship to the Insured	Address (Street Address, City, State, Zip Code)
1)			
2)			
3)			
4)			
If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary after his/her name above. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries who survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.			
Dependent Life Insurance - You may choose to enroll for dependent life and accidental death and dismemberment insurance 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 I -- \$5,000 for your spouse and \$2,000 for each child	<input type="checkbox"/> Plan III -- \$15,000 for your spouse and \$ 7,000 for each child
		<input type="checkbox"/> Plan II -- \$10,000 for your spouse and \$ 4,000 for each child	<input type="checkbox"/> Plan IV -- \$20,000 for your spouse and \$10,000 for each child
Dependent Name (Last, first, middle initial)	Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship
			___ Wife ___ Husband
			___ Daughter ___ Son
			___ Daughter ___ Son
			___ Daughter ___ Son
			___ Daughter ___ Son
Other specify below**			
*Date of Marriage or Adoption, if applicable. To add a dependent to your health coverage, you must complete a Change-In-Status form.			
**Must be eligible dependent according to PEIA rules. See your PEIA Summary Plan Description for details. Specify relationship:			
Selection, Acceptance, and Payroll Deduction Authority - I am enrolling for (Mark all that apply):			
<input type="checkbox"/> Optional Life Insurance <input type="checkbox"/> Dependent Life Insurance (spouse and/or child)			
You must mark ONE of the following statements:			
<input type="checkbox"/> The benefits have been explained to me, and I decline to participate.			
<input type="checkbox"/> The benefits have been explained to me, and I hereby accept the forms of group coverage indicated above, and authorize deduction of my premium contribution from my earnings until revoked by me in writing. I understand that the PEIA may change the types or levels of benefits or the amount of contribution.			
Employee's Signature _____		Date _____	

Agency Name		Account Number	
OPT Plan	Dep Plan	Date of Employment	Effective Date of Coverage
I hereby certify that the information above is true to the best of my knowledge, and that the employee is eligible for coverage under PEIA.			
Authorized Signature _____		Date _____	

Optional and Dependent Life Insurance Enrollment Form (OPT)

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit agency account number as it appears on your billing.

OPT Plan: Use the option code below based on the plan chosen by the employee.

Active Employee Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	300
Plan IV	400
Plan V	500
Plan VI	600
Plan VII	650
Plan VIII	700
Plan IX	750
Plan X	800
Plan XI	900
Plan XII	950
Plan XIII	951
Plan XIV	952
Plan XV	953
Plan XVI	954
Plan XVII	955
Plan XVIII	956

If an employee chooses more than \$100,000 of coverage, he or she will be required to complete an Evidence of Insurability Application form.

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400

Please note that if documentation is required for a dependent and cannot be submitted with the Optional and Dependent Life Insurance Enrollment form, **the form on page 9 should accompany submission of the documentation to PEIA.**

Date of Employment: Date of full-time employment for the employee with your agency.

Effective Date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the form and returns it to you to elect the coverage), as long as it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application; PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. We will contact you when the medical underwriting decision has been made. Remember that the employee must be actively at work for coverage (or an increase in the amount of coverage) to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Notice of Death

Minnesota Life Insurance Company - A Securian Company • Refer completed Claims to:
Public Employee Insurance Agency • Capital Complex • Building 5, 10th floor • Charleston, WV 25305-0710
Toll free 1-888-680-7342



MINNESOTA LIFE

TYPE OF CLAIM: Active Employee Retiree Dependent

Attach a certified copy of the official death certificate.

PART 1 - EMPLOYEE INFORMATION (to be completed by the employer)

1. Employee name (last, first, middle initial)		2. Employee Social Security number
3. Employee address (street, city, state, zip)		4. Employee telephone number ()
5. Employee date of hire (mo/day/yr)	6. Effective date of employee's insurance (mo/day/yr)	7. Employee actively at work on effective date? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART 2 - DECEASED INFORMATION (to be completed by the employer)

1. Name of deceased	2. Deceased's Social Security number	3. Relationship to employee	4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
5. If dependent, effective (mo/day/yr) date of dependent's insurance?	6. Date of birth (mo/day/yr)	7. Date of death (mo/day/yr)	8. Was death due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART 3 - EMPLOYER'S CERTIFICATION

1. Name of employer, association or fund		2. Telephone number ()
3. Address of employer, association or fund (street, city, state, zip)		4. Account number
Signature of authorized representative X	Date signed	Title

PART 4 - BENEFICIARY STATEMENT (You must sign both signature lines below.) (WITHOUT A COMPLETED IRS FORM W-9 BY THE BENEFICIARY, THE BENEFICIARY MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.)

1. Print name of beneficiary (last, first, middle initial)		2. Other names by which the deceased has been known, if any	
3. Relationship to deceased	4. Beneficiary's Social Security number	5. Beneficiary's date of birth	6. Beneficiary's telephone number ()
7. Beneficiary's address (street, city, state, zip)			
Beneficiary's signature X		Date	

CERTIFICATION INSTRUCTIONS: You must cross out item (2) below if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return.

CERTIFICATION – Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Social Security number or Taxpayer Identification number, **and**
- (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, **and**
- (3) I am a U. S. person (including a U. S. resident alien).

Certification Notice: THE IRS REQUIRES US TO OBTAIN CERTIFICATION OF YOUR SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER. WITHOUT THIS INFORMATION, YOU MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING FOR ANY INTEREST PAID ON THE DEATH BENEFIT.

Beneficiary's signature X	Date
-------------------------------------	------

PART 5 - PEIA CERTIFICATION I certify that on the date of death, the above named was insured under this policy. I further certify that the information provided above is true and correct to the best of my knowledge and belief. (Attach a copy of enrollment form.)

1. Employer/policyholder name PEIA	2. Coverage code	3. Plan/policy number 33227	4. Date to which premiums were paid for deceased (mo/day/yr)
5. Amount of insurance Basic \$ _____ Optional \$ _____ Dependent \$ _____ Total \$ _____			
Signature of authorized PEIA representative X		Date signed	Telephone number ()

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

F1471-PEIA Rev 11-2010

Notice of Death

You complete Part 4 – Employer’s Certification

1. **Name of employer, association or fund:** Your agency name as it appears on your PEIA monthly billing.
2. **Telephone Number:** Enter your work phone number.
3. **Address of employer, association or fund:** Enter your agency’s mailing address.
4. **Account number:** Enter the agency account number from your PEIA monthly billing
5. **Signature of authorized representative:** Sign here.
6. **Date signed:** The date you signed the form. Forms should be signed immediately upon receipt .
7. **Title:** Enter your job title.

You may also need to fill in some information at the top of the form, such as, in Part 1, boxes 9, 10 and 11 -- the employee’s date of hire, the effective date of the employee’s insurance, and verification of actively at work. And in Part 3, boxes 7, 8 and 9 -- the effective date of the dependent’s insurance, verification of premium payment, and the amount of coverage.

**Waiver of Premium Claim
Employer's Statement**

Minnesota Life Insurance Company - A Securian Company • Claims
Charleston Branch Office • PO Box 3742 • Charleston, WV 25337-3742 • Toll free 1-800-203-9515



MINNESOTA LIFE

Policyholder's name PEIA		Policy number 33227	Branch code	Coverage code
Insured employee's name (last, first, middle initial)		Employee ID	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street address				
Date of birth (mo/day/yr)	Date employed (mo/day/yr)	Social Security number		
Job title	Date last worked			
Status on employment date <input type="checkbox"/> Full time <input type="checkbox"/> Part time If part-time, average hours per week. _____				

Amount of Employee's Insurance Effective Date of Coverage
Basic \$ _____

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

Name of employer	Employer's telephone number
Employer's address	
Authorized signature X	Date

F53421-PEIA Rev 10-2010

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

Waiver of Premium Claim

(Disability Waiver of Premium)

If you have an employee applying for a disability waiver of premium, the Employer's Statement must be completed by you.

Type of Claim: Mark whether the policyholder is an active employee or a retiree.

Account number: Enter the agency account number from your PEIA monthly billing

Coverage Code: Mark with code **LB01** for basic life. The premium can only be waived for the basic life insurance. Premiums must be paid by the policyholder for any optional coverage to keep it in force.

Insured employee's name: Enter the policyholder's full name.

Employee ID: Enter the policyholder's social security number.

Gender: Indicate the gender of the policyholder.

Street Address: Enter the policyholder's home address.

Date of Birth: Enter the policyholder's date of birth.

Date Employed: Date of full-time employment for the employee with your agency.

Social Security Number: Enter the policyholder's social security number.

Job Title: Enter the job title of the policyholder.

Date last worked: Indicate the last date that the employee was actively at work on a full-time basis.

Status on employment date: Indicate whether the employee was full-time or part time.

Amount of Employee's insurance: Fill in the amount of basic life insurance on the employee and the effective date of coverage.

Employer Certification:

Name of Employer: Your agency name as it appears on your PEIA monthly billing.

Telephone Number: Enter your work phone number.

Address: Enter your agency's mailing address

Authorized Signature: Your signature as the Benefit Coordinator

Date: The date you signed the form. Forms should be signed immediately upon receipt.

When the form is completed, submit it to WVPEIA, State Capitol Complex, Bldg. 5, Rm. 1001, 1900 Kanawha Blvd. E, Charleston, WV 25305-0710.

**State of West Virginia ★ Public Employees Insurance Agency
Retirement Health Benefits and Basic Life Insurance Enrollment Form**



Please read and follow the instructions on the back of this form when completing it. Use this form to enroll for PEIA health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. Complete all sections of the form except the last section, "AGENCY", and return the completed form to your benefit coordinator.

RETIREE	Name (Last) (First) (MI) (Generation: Jr., Sr., etc)			Social Security Number
	Street Address		County of Residence	Home Phone () ()
	City	State	Zip	Work Phone () ()
	Date of Birth (mm/dd/yyyy)	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	I decline participation in any health or life insurance coverage. Signature _____ Date _____	

FAMILY INFORMATION	1) Were you recently covered by any health benefits plan for a period of at least three (3) months? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Termination Date: _____						
	2) Provide the date when you were or when you will be entitled to Medicare coverage. Effective Date: _____						
	3) Complete the following information for all dependents who will be covered under your plan. (Include Medicare under Other Insurance)						
	Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)	Sex/Category (see instruction on back of form)	Birth Date (mm/dd/yyyy)	Social Security Number	Other Insurance (Plan Name)
			SP CH				

BASIC LIFE BENEFICIARY	Beneficiary Name (Last, First, MI, Generation)	Beneficiary Address (Street, City, State, Zip)	Social Security Number	Relationship to the Insured	Distribution % (Total Must Equal 100%)

COVERAGE	COVERAGE SELECTION (Select One) I am enrolling for:	EARNED EXTENDED BENEFITS (Sick and/or Annual Leave Credits) Complete if you have sick and/or annual leave credits. I choose to use my credits to:	DEDUCTION AUTHORITY
	<input type="checkbox"/> Policyholder Only Health and Life (specify plan) _____	<input type="checkbox"/> Extend my employer-paid insurance coverage. <i>Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining accrued leave.</i>	<input type="checkbox"/> I authorize annuity deduction for any required premium beginning immediately after my earned extended coverage ends.
	<input type="checkbox"/> Family Health and Life (specify plan) _____	<input type="checkbox"/> Increase my annuity amount (Complete proper forms from CPRB)	<input type="checkbox"/> I authorize annuity deduction for any required premium. I am not using leave credit for insurance.
	<input type="checkbox"/> Life Insurance Only (NO health benefits)		<input type="checkbox"/> I DO NOT authorize annuity deductions. I request that my coverage terminate at the end of my earned extended coverage.

AFFIDAVIT	Tobacco Affidavit Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your PEIA coverage uses tobacco, you will receive a discount on your PEIA PPB Plan health coverage (if any) and optional life insurance premiums. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.
	Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last six (6) months

ACCEPTANCE	I hereby accept the group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the choices I have made may affect my contributions. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that 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 health care plan I have selected, of all 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.
	Signature: _____ Date: _____

AGENCY	To Be Completed By The Employer:			
	Agency Name	Active Account Number	Retiree Account Number	Coverage Code
	Last Date of Active Employment	Effective Date of Retirement	Effective Date of Retiree Insurance Coverage	
	Number of days of accrued sick and annual leave for which the employee was not paid when employment ceased:	Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 month family coverage) Partial months are not allowed.	Higher Education Extension (FACULTY ONLY) 3-1/2 years service = 1 year single coverage 5 years service = 1 year family coverage Total years of extended coverage (in months):	Total WV State Government credited years of service:
	I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.			

Authorized Signature: _____ Date: _____
WHITE - PEIA GREEN - Managed Care CANARY - Payroll Location PINK - CPRB GOLDENROD - Employee Revised November 2004

Instructions for Retirement Health Benefits and Basic Life Insurance Enrollment Form

Please follow these instructions carefully when completing this form.

RETIREE

Complete ALL demographic information. The "Generation" area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III, IV, etc.

If you ***do not*** wish to enroll for health or life insurance coverage as a retiree, sign and date the box stating "I decline participation ..." and return the form to your benefit coordinator.

FAMILY INFORMATION

1) Please give us information about health insurance that you had during the last three months of your active employment.

If you are currently in the PEIA PPB Plan or one of the managed care plans offered by PEIA, please write in the name of the plan you're in; you do not need to include a termination date.

If you had coverage from another insurer, in the space provided, please write in the plan name and termination date, and attach a certificate of creditable coverage from the other insurer to this form.

2) We need information about Medicare coverage for you. Your premium decreases when you are retired and have Medicare. Please provide the date when you were or will become eligible for Medicare (typically age 65, unless you have a disability). When you become eligible for Medicare, it is important that you enroll for both Medicare Parts A and B. Please see your Summary Plan Description for more information.

3) We need to know about any dependents to be covered under your health insurance. Please complete the chart. In column titled "Sex/Category", include gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). The relationship codes are:

- | | |
|----------------------------------|----------------------------------|
| 1. Child (biological or adopted) | 4. Court-Ordered Dependent Child |
| 2. Step-child | 5. Student(age19-25) |
| 3. Grandchild | 6. Other |

If adding a dependent child other than your biological or adopted child, notarized documentation is required showing that the child is completely dependent upon the policyholder for financial support.

BENEFICIARY

Your health insurance includes a basic decreasing term life insurance policy on you. Please designate the beneficiary(s) of this basic term life insurance policy in the "Basic Life Insurance Beneficiary" section. Please consult your insurance coordinator if you have questions about the amount of life insurance coverage you have. The life insurance proceeds will be distributed equally among all designated beneficiaries unless you specify otherwise on this form. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who dies before the policyholder will be distributed equally among all surviving named beneficiaries. If no beneficiary survives the employee, payment will be made in accordance with the terms of the policy. The name of the beneficiary should be written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe."

COVERAGE

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are continuing your health care coverage into retirement, you must remain the health care plan you were in as an active employee through the end of the plan year (June 30), unless you were in a managed care plan and will be Medicare-eligible when you retire. Please be sure to fully specify the plan you want, including the plan name and any option, such as PEIA PPB Plan A or The Health Plan Plan B. For life insurance, on this form, you can continue your basic life insurance. If you wish to continue Optional and/or Dependent coverage, you must complete the Retiree Optional Life Insurance form.

Earned Extended Benefits: If you have sick and/or annual leave credits, you must specify how you want to use those credits. You may use them to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. If you have been in the Plan since before July 1, 1988, your accrued leave days will pay 100% of your monthly premium. If you came into the Plan after July 1, 1988, but before July 1, 2001, your accrued leave days will pay 50% of your monthly premium. For details, please see your Summary Plan Description. If you were hired after July 1, 2001, you cannot use sick/annual leave credits to extend employer-paid insurance coverage.

Deduction Authority: Please indicate how you will pay your premiums by checking the appropriate box.

AFFIDAVIT

PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discounts.

ACCEPTANCE

When you have made your selections on this form, you must sign and date the "Acceptance" box.

COMPLETING THE PROCESS

When your form is complete, return it to the benefit coordinator at your place of employment (or to the Consolidated Public Retirement Board, if you are already retired). Your benefit coordinator will complete the Agency portion of the form and submit it for processing.

Public Employees Retirement Health Benefits and Basic Life Insurance Enrollment Form (PERS)

Complete the Agency information at the bottom of the form.

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Retiree Account Number: Leave blank.

Coverage Code: Please use one of the codes below to indicate which plan the policyholder chose:

HI01	PEIA PPB Plan A
HMHP - A	Health Plan HMO Plan A
HMHP - B	Health Plan HMO Plan B

Remember that PEIA PPB Plan B is not available to retired employees, and that only NON-MEDICARE retirees are eligible for the managed care plans.

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Policyholder Only
F = Policyholder, Spouse and Children
C = Policyholder and Children Only
S = Policyholder and Spouse Only

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. ESPS is based on the active member's salary, and they only receive ESPS if the active member carries health coverage,

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-F**.

Option: Choose from the following option codes for the coverage selected.

Retiree Option Codes	
Non-Medicare Retiree (Plan A or managed care only)	011
Medicare Retiree	012

Last Date of Active Employment: The last day the employee is on payroll.

Effective Date of Retirement: Enter the effective date of the employee's retirement

Effective Date of Coverage: Usually the same as the effective date of retirement. Coverage for retirees is continuous as long as forms are completed and signed during the retirement event enrollment period.

Number of days of accrued sick and annual leave for which the employee was not paid when employment ceased: complete this if the employee elected to extend employer-paid insurance coverage.

Number of earned extended insurance coverage: calculate the months of extended coverage if the employee elected to extend employer-paid insurance coverage.

Higher Education Extension (Teaching Service): complete if applicable. Please be sure to calculate the total to MONTHS of coverage. See page 18 of the Eligibility section.

Total WV State Government credited years of service: Leave blank.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

**State of West Virginia
Public Employees Insurance Agency
Retired Employee's Optional and Dependent Life Insurance Enrollment Form**



Complete this form to enroll for, continue or increase life insurance coverages. Complete all sections of the form except the last section titled "AGENCY".

R E T I R E E	Name (Last) (First) (MI) (Generation)			Social Security Number			
	Sex (Mark One) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yyyy)		Work Phone ()		
	Street Address		City	State	Zip Code		
					Home Phone ()		
	Optional Life Insurance - If you have enrolled in basic life insurance, you may choose to enroll for optional life insurance for yourself. If you choose a plan higher than what you have as an active employee, you must complete and attach a Medical Information Form, and be approved by the life insurance carrier. To enroll for coverage, check the box beside the amount of life insurance you desire:						
	Retiree's Age Under age 65 Age 65 to 69 Age 70 and above		<input type="checkbox"/> Plan I \$5,000 3,250 2,500	<input type="checkbox"/> Plan II \$10,000 6,500 5,000	<input type="checkbox"/> Plan III \$15,000 9,750 7,500	<input type="checkbox"/> Plan IV \$20,000 13,000 10,000	<input type="checkbox"/> Plan V \$30,000 19,500 15,000
	Retiree's Age Under age 65 Age 65 to 69 Age 70 and above		<input type="checkbox"/> Plan VI \$40,000 26,000 20,000	<input type="checkbox"/> Plan VII \$50,000 32,500 25,000	<input type="checkbox"/> Plan VIII \$75,000 48,750 37,500	<input type="checkbox"/> Plan IX \$100,000 65,000 50,000	<input type="checkbox"/> Plan X \$150,000 97,500 75,000
	Please designate the beneficiary(s) of your optional life insurance coverage below. You may change your beneficiary at anytime by filing a form with PEIA. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe".						
	Beneficiary Name (Last, First, Middle Initial)		Relationship to the Insured	Social Security Number	Address (Street Address, City, State, Zip Code)		
	1)						
2)							
3)							
4)							
If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary after his/her name above. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries who survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.							
Dependent Life Insurance -- You may choose to enroll for dependent life insurance for your spouse and/or children. The beneficiary of the dependent life insurance policy is the employee. If you choose a plan higher than what you have as an active employee, you must complete and attach a Medical Information Form, and be approved by the life insurance carrier. To enroll, check the box beside the amount of dependent life insurance you desire.							
To enroll for dependent life insurance, mark the plan of your choice and complete the following information:		<input type="checkbox"/> Plan I -- \$ 5,000 for your spouse and \$ 2,000 for each child <input type="checkbox"/> Plan II -- \$10,000 for your spouse and \$ 4,000 for each child		<input type="checkbox"/> Plan III -- \$ 15,000 for your spouse and \$ 7,000 for each child <input type="checkbox"/> Plan IV -- \$ 20,000 for your spouse and \$ 10,000 for each child			
Dependent Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (mm/dd/yyyy)	Relationship _____ Wife _____ Husband _____ Daughter _____ Son _____ Daughter _____ Son _____ Daughter _____ Son _____ Daughter _____ Son	Date Eligible* (mm/dd/yyyy)			
			Other specify below**				
*Date of Marriage or Adoption, if applicable. To add a dependent to your health coverage, you must complete a Change-In-Status form. **Must be eligible dependent according to PEIA rules. See your PEIA Summary Plan Description for details. Specify relationship: _____							
Selection, Acceptance and Deduction Authority - I am enrolling for (Mark all that apply): <input type="checkbox"/> Optional Life Insurance <input type="checkbox"/> Dependent Life Insurance (spouse and/or child) You must mark ONE of the following statements: <input type="checkbox"/> The benefits have been explained to me, and I decline to participate. <input type="checkbox"/> The benefits have been explained to me, and I hereby accept the terms of group coverage indicated above, and authorize deduction of my premium contribution from my earnings until revoked by me in writing. I understand that the PEIA may change the types or levels of benefits or the amount of contribution.							
Retired Employee's Signature: _____			Date: _____				

A F F I D A V I T	Tobacco Affidavit	
	Please mark which members of the family (if any) use tobacco and sign the affidavit. If none of the people enrolled on your PEIA coverage uses tobacco you will receive a discount on your health and life insurance premiums.	
	Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No tobacco users in the last six months	
	I certify that this information is correct, and agree that if this information changes before the effective date of my coverage I will notify the plan of such change in writing. I acknowledge by signing this form that WVPEIA or its agents have access to my medical records to check my tobacco use status. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted.	
Employee's Signature: _____		
Date: _____		

A G E N C Y	To Be Completed By The Employer:			
	Agency Name		Account Number	
	OPT Plan	Dep Plan	Date of Retirement	Effective Date of Coverage
	I hereby certify that the information above is true to the best of my knowledge, and that the employee is eligible for coverage under PEIA.			
Authorized Signature: _____		Date: _____		

Retired Employees Optional and Dependent Life Insurance Enrollment Form

Complete the Agency information at the bottom of the form.

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

OPT Plan: Use the option code below based on the plan chosen by the employee.

Retiree Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	250
Plan IV	300
Plan V	400
Plan VI	500
Plan VII	600
Plan VIII	700
Plan IX	800
Plan X	900

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400

Please note that if documentation is required for a dependent and cannot be submitted with the enrollment application, **the form on page 9 should accompany submission of the documentation to PEIA.**

Date of Retirement: Enter the effective date of the employee's retirement

Effective Date of Coverage: Usually the same as the effective date of retirement. Coverage for retirees is continuous as long as forms are completed and signed during the retirement event enrollment period.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

**State of West Virginia
Public Employees Insurance Agency
Surviving Dependents - Health Benefits Enrollment Form**

SD

Complete this form to enroll for or continue PEIA health insurance coverage as a surviving dependent.
Complete all sections of the form except the last section titled "AGENCY".

S D U R V I V D I E N N G T	Name (Last) (First) (MI) (Generation)				
	Sex (Circle One) M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (MM/DD/YY)	Social Security #	Have you previously been covered by PEIA? YES <input type="checkbox"/> NO <input type="checkbox"/>	Other Insurance (Plan Name) If Any
	Street Address		County of Residence		Home Phone ()
	City		State	Zip	Work Phone ()
	Deceased Name: _____ SSN: _____			Date of Death	If you do not wish to participate in PEIA coverage, please indicate below, sign and return this form to your insurance coordinator. I decline to participate in any PEIA coverage. Signature: _____ YES <input type="checkbox"/>

F A M I L Y I N F O R M A T I O N	1) Were you recently covered by any other health benefits plan for a period of at least three (3) months? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, provide the following information: Insurance Company (Plan Name) _____ Termination Date _____							
	2) Please show the date when you were or when you will be entitled to Medicare coverage. Effective Date: _____							
	If you are enrolling for family survivor's health coverage, please complete the following information for all dependents who will be covered under your plan. If any of your dependents were previously covered as a dependent by PEIA, please enter a 'Y' in the last column titled "Prev. Covg?" (NOT eligible unless previously covered).							
	Name (Last, First, MI, Generation)	Address (If different from above)	Relationship (Circle One)	Sex/Category M/F	Birth Date (MM/DD/YY)	Social Security #	Other Insurance (Plan Name)	Prev. Covg?
			SP CH					
			SP CH					

CATEGORY for Dependent Child(ren):
 1. Child (biological or adopted) 3. Grandchild 5. Student (age 19-25)
 2. Step-child 4. Court-Ordered Dependent Child 6. Other

In dependent column titled "Sex/Category", please write (e.g., M1 for Male Child; F3 for Female Grandchild; F26 for Female Step-child/Student, etc.).

C O V E R A G E	Please indicate the benefit plan for which you are enrolling:		Please indicate the type of PEIA plan for which you are enrolling:	
	1 <input type="checkbox"/>	Single Survivor's Health Coverage (no dependents)	1 <input type="checkbox"/>	PEIA Indemnity Plan
	2 <input type="checkbox"/>	Family Survivor's Health Coverage	2 <input type="checkbox"/>	Managed Care Plan (Indicate Plan Name Below: _____) Check Option if Applicable: HMO <input type="checkbox"/> POS <input type="checkbox"/>
The benefits have been explained to me, and I hereby accept the forms of group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution. I hereby authorize release of all medical and prescription information needed to process claims or review utilization.				
Applicant's Signature: _____			Date: _____	

To Be Completed By The Employer:

A G E N C Y	Agency Name	Account Number	Region
	Effective Date of Coverage	Coverage Code	Termination Date of Deceased Employee's Coverage
	I hereby certify that this information is true and this surviving dependent meets the minimum eligibility requirements for the Public Employees Insurance Plan. Authorized Signature: _____ Date: _____		

WHITE - PEIA YELLOW - Managed Care Plan PINK - Payroll Location GOLDENROD - Employee

PEIA - 5005
Revised July 1998

Surviving Dependent Enrollment Form

Complete the Agency portion at the bottom of this form.

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Region: No longer required on the Surviving Dependent Enrollment Form.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the survivor signs the forms to elect the coverage).

Coverage Code: Please use one of the codes below to indicate the survivor's plan:

HI01	PEIA PPB Plan A
HMHP - A	Health Plan HMO Plan A
HMHP - B	Health Plan HMO Plan B

Remember that the survivor has to continue coverage in whichever plan he or she was in at the time of the policyholder's death. The survivor will pay the same premium as a retiree with 25 or more years of service. Another choice can be made during the next open enrollment

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Survivor Only
C = Survivor and Children Only

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-C**.

Remember that survivors are not eligible for life insurance.

Termination Date of Deceased Employee's Coverage: This date should be the last day of the calendar month in which the employee died. If the employee died on January 1st, the termination date would be January 31st.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the survivor.

Earl Ray Tomblin
Governor



Ted Cheatham
Director

WV Toll-free: 1-888-680-7342 • Phone: 1-304-558-7850 • Fax: 1-304-558-2470 • Internet: www.wvpeia.com

**AUTHORIZATION TO REMOVE
BENEFIT COORDINATOR/WEB CONTRIBUTIONS COORDINATOR**

Please remove the following individual as an active Public Employees Insurance Agency

- Benefit Coordinator
- Web Contributions Coordinator

Employee Name: _____

Employee E-Mail Address: _____

Agency Name: _____

Effective Date of Removal: _____

Authorized by (print name): _____

Title: _____ Phone: _____

Signature: _____ Date: _____

601 – 57th Street, SE • Suite 2 • Charleston, WV 25304-2345
An equal opportunity employer.

The forms on the following pages are not specifically for use by Benefit Coordinators, and do not require the Benefit Coordinator's signature. We are including them in this book for your convenience and reference.

Forms included here are:

Combining of Accrued Sick and/or Annual Leave form
Request for Refund of Premium
Beneficiary Statement (Minnesota Life)

State of West Virginia
Public Employees Insurance Agency

**COMBINING OF ACCRUED
SICK AND/OR ANNUAL LEAVE**

Retired Employee's Name _____	Spouse's Name _____
Retired Employee's Social Security No. _____	Spouse's Social Security No. _____
Retired Employee's Agency Name _____	Spouse's Agency Name _____
Retired Employee's Agency Account No. _____	Spouse's Agency Account No. _____

Please indicate which retired employee will carry the:

Family Plan _____ (Name)

Basic Life Insurance Only** _____ (Name)

**The premium for the basic life insurance will be deducted from monthly annuity.*

Retiree 1: _____ (Signature) _____ (Day)

Retiree 2: _____ (Signature) _____ (Day)

8.24.98/its

West Virginia Public Employees Insurance Agency

REQUEST FOR REFUND OF PREMIUM

TO WHOM SHOULD THIS REFUND BE ISSUED?

SSN OR FEIN:

TO WHAT ADDRESS SHOULD THIS REFUND BE SENT?

UNDER WHICH ACCOUNT NUMBER WAS THE OVERPAYMENT MADE?

IN WHICH MONTH(S) WAS THE OVERPAYMENT MADE?

PLEASE INDICATE THE TOTAL PAYMENTS MADE FOR THIS EMPLOYEE/RETIREE DURING THIS PERIOD:

EMPLOYER CONTRIBUTION: _____ EMPLOYEE/RETIREE CONTRIBUTION: _____

TOTAL REFUND DUE FOR THE MONTH(S) LISTED ABOVE:

\$ _____

PLEASE EXPLAIN IN DETAIL WHY A REFUND IS BEING REQUESTED:

AUTHORIZED SIGNATURE:

DATE:

THIS FORM MUST BE COMPLETED AND SIGNED BY THE BENEFIT COORDINATOR OR PAYROLL OFFICER

Beneficiary Statement

Minnesota Life Insurance Company - A Securian Company • Claims
 Charleston Branch Office • PO Box 3742 • Charleston, WV 25337-3742 • Toll free 1-800-203-9515



MINNESOTA LIFE

PART 1 – All fields must be completed in Part 1 including your signature

Name of deceased (last, first, middle initial)		Policy number 33227	CLAIM NUMBER
Other names by which the deceased has been known, if any			
Address prior to death (street, city, state, zip)			
Date of birth (mo/day/yr)		Date of death (mo/day/yr)	
Name of beneficiary (last, first, middle initial)			
Relationship to deceased		Beneficiary's date of birth	

CERTIFICATION INSTRUCTIONS: You must cross out item (2) below if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return.

CERTIFICATION – Under Penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Social Security Number or Taxpayer Identification Number, **and**
- (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, **and**
- (3) I am a U. S. person (including a U. S. resident alien).

CERTIFICATION NOTICE: The IRS requires us to obtain certification of your Social Security number or Taxpayer Identification number. Without this information, you may be subject to government imposed backup withholding for any interest paid on the death benefit.

Signature of beneficiary X	Date	Beneficiary's Social Security number
Address of beneficiary (street, city, state, zip)		Telephone number of beneficiary
Signature of witness X	Date signed	
Address of witness (street, city, state, zip)		

A CERTIFIED COPY OF THE PUBLIC DEATH RECORD IS REQUIRED AS PROOF OF DEATH

PART 2 – PAYMENT INFORMATION (Benefits will be sent to you via a check if Part 2 is not fully completed and signed.)

How would you like to receive the proceeds payable to you?
 Check Direct Deposit - if you select this option, you must complete and sign the bottom of this form.

Authorization for Direct Deposit

I authorize Minnesota Life Insurance Company ("Company") to initiate deposits (credit entries) and corrections (debit entries) to adjust any deposits made in error to my account indicated below. I authorize the financial institution ("Depository") named below to accept these deposits and/or corrections made to this account.

This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on it or until such time as Company terminates this method of payment.

Name of depository (bank, credit union, etc.)		Depository telephone number	
Street	City	State	Zip code
Account type <input type="checkbox"/> Savings <input type="checkbox"/> Checking	Bank routing/transit number	Account number	

IMPORTANT: For purposes of accuracy, **PLEASE ATTACH A VOIDED CHECK OR SAVINGS DEPOSIT SLIP.**

Signature of beneficiary X	Date signed
--------------------------------------	-------------

PART 3 – NOTICE

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

F5562-PEIA Rev 11-2010