[

State of West Virginia ★ Public Employees Insurance Agency

Health Benefits Enrollment Form

HEALTH

Complete this form to enroll for PEIA health insurance coverage. Complete all sections of the form except the last section, "AGENCY"

EMPLOYMENT

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 ☐ NO ☐

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:

FAMILY INFORMATION

Is spouse currently insured by PEIA as a policyholder? ☐ Yes ☐ No If YES, provide spouse's Social Security Number (SSN): _____

Please complete the following information for all dependents who will be covered under your plan:

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				

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

COVERAGE

COVERAGE SELECTION (Select One) I am enrolling for:

- 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:

- 1 ☐ PEIA PPB Plan A
- 2 ☐ PEIA PPB Plan B
- 3 ☐ PEIA PPB Plan C
- 4 ☐ The Health Plan HMO Plan A
- 5 ☐ The Health Plan HMO Plan B

AFFIDAVIT

Tobacco Affidavit

You must complete this affidavit. Please mark which members of the family use tobacco and sign the affidavit. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your health and life insurance premiums; to receive the discount, please mark the No Tobacco Users box and sign the affidavit. 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

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. 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:

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 June 16, 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 as 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.**

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 % *Total must equal 100%*

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: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ 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 **LB0**1 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 sections "AGENCY" and "PEIA" and return to your benefit coordinator.

EMPLOYEE

Name (Last) (First) (MI) (Generation: Jr., Sr., etc.) Social Security Number

Street Address Check if New Address ☐ 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 ☐ NO ☐

CHANGE TYPE

Please indicate the type of status change you are making:

- 001 ☐ Change name as listed above to: (Last) _____ (First) _____ (MI/Gen) _____
- 002 ☐ Transfer employee's premium billing from Employer Account # _____ To Account # _____ within the same agency
- 003 ☐ Add Dependents to: Mark your choice(s): ☐ Health ☐ Dependent Optional Life Insurance (Check one) ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4
  If outside the initial enrollment period, an Evidence of Insurability Application for Coverage is required for life insurance coverage.
- 004 ☐ Remove Dependents from: Mark your choice(s): ☐ Health ☐ Dependent Optional Life Insurance
- 005 ☐ Change in managed care plan *(Requires PEIA approval if outside open enrollment)*
  From: (Plan Name) _____ To: (Plan Name) _____
- 006 ☐ Add Health coverage. (Check only one) ☐ 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

DEPENDENT

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				

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

REASON

Policyholder must provide documentation for every type of status change.

- 1 ☐ Marriage
- 2 ☐ Divorce
- 3 ☐ Birth of Child
- 4 ☐ Adoption
- 5 ☐ Death of spouse or dependent
- 6 ☐ Beginning or end of spouse's employment
- 7 ☐ Significant change in health coverage due to spouse's employment
- 8 ☐ Unpaid leave of absence by employee or spouse
- 9 ☐ Ineligibility of dependent child due to age, marriage, or loss of full-time student status
- 10 ☐ Change from full-time to part-time employment or vice-versa for employee or spouse
- 11 ☐ Open Enrollment
- 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 maintain documentation of this event, and I may be requested to provide this documentation to the WV Public Employees Insurance Agency, my employer, or the Internal Revenue Service for Section 125 purposes.

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 Acordia National, 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:

AFFIDAVIT

Tobacco Affidavit

You must complete this affidavit. Please mark which members of the family use tobacco and sign the affidavit. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your health and life insurance premiums; to receive the discount, please mark the No Tobacco Users box and sign the affidavit. 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

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:

AGENCY

To Be Completed By The Employer:

Agency Name Agency Address (*Include City, State and Zip Code*)

Account Number Index Code Coverage Code OLD _____ NEW _____ Effective Date of This Status Change

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:

PEIA

To Be Completed By The Public Employees Insurance Agency:

For purposes of the Premium Conversion Plan, this family status change has been:

Approved ☐ Denied ☐ Pended for Further Information ☐

Authorized PEIA Signature: Date:

Please submit only the original to PEIA

Revised June 16, 2010

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 reflects 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		
	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

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:

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 as 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.**

Earl Ray Tomblin
Governor

Ted Cheatham
Director

WV Toll-free: 1-888-680-7342 • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.wvpeia.com

To: PEIA Eligibility Documentation Unit

From: _____ Date: _____
(policyholder's name)

Re: Unique ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **OR**

Last four digits of SSN ■■■ - ■■ - ☐☐☐☐

Please mark the type of transaction you're documenting and the documentation attached.

	Status Change Event	Documentation Required
	Divorce	Provide a copy of the divorce decree showing that the divorce is final. The ex-spouse is not eligible for coverage as of the end of the month in which the divorce became final.
	Marriage	Copy of valid marriage license or certificate
	Birth of Child	Copy of child's birth certificate
	Adoption	Copy of adoption papers
	Adding coverage for a child who resides with the policyholder and for whom the policyholder is 100% financially responsible	Court-ordered guardianship papers.
	Open Enrollment under spouse's employer's benefit plan	A copy of printed material showing open enrollment dates and the employer's name.
	Death of spouse or dependent	A copy of the death certificate.
	Beginning of spouse's employment	A letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered.
	End of spouse's employment	A letter from the spouse's employer stating the termination or retirement date, what coverage was lost, and dependents that were covered.
	Unpaid leave of absence by employee or spouse	A letter from your or your spouse's personnel office stating the date that you or your spouse went on unpaid leave or returned from unpaid leave.
	Significant Change in Health Coverage Attributable to Spouse's Employment	A letter from the spouse's insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered.
	Ineligibility of dependent child due to age	Copy of the dependent's birth certificate
	Change from full-time to part-time employment or vice versa for employee or spouse	A letter from your or your spouse's employer stating the previous hours worked and the new hours worked and the effective date of the change.
I understand that PEIA cannot process my enrollment or change in enrollment for me or my dependents until these documents have been received.		

Please send this cover sheet with your documents to the address below.

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

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? ☐ Yes ☐ No If YES, provide spouse's Social Security Number (SSN): _____

TERMINATION REASON

Check Appropriate Box:

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

☐ 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 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

CIA

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.

EMPLOYEE

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

☐ Health ☐ Optional Life
☐ Basic Life ☐ Optional Dependent Life

CHANGE TYPE

NEW ADDRESS OF POLICYHOLDER Street	County of Residence	Home Phone ( )
City State	Zip	Work Phone ( )
Effective Date of New Address	Employee's Signature	

DEPENDENT

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)
2. Step-child
3. Grandchild
4. Court-Ordered Dependent Child
5. Student (age 19-25)
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:

AGENCY

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

CB

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

EMPLOYEE

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 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)

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.)

AGENCY

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.

OPT

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

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.

EMPLOYEE

Name (Last)	(First)	(M)	Social Security Number
Gender (check one) ☐ Male ☐ 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 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:

Employee's Age	☐ Plan I	☐ Plan II	☐ Plan III	☐ Plan IV	☐ Plan V	☐ Plan VI	☐ Plan VII	☐ Plan VIII	☐ Plan IX
Under age 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$75,000	$80,000
Age 65 to 69	3,250	6,500	13,000	19,500	26,000	32,500	39,000	48,750	52,000
Age 70 and above	2,250	4,500	9,000	13,500	18,000	22,500	27,000	33,750	36,000

Employee's Age	☐ Plan X	☐ Plan XI	☐ Plan XII	☐ Plan XIII	☐ Plan XIV	☐ Plan XV	☐ Plan XVI	☐ Plan XVII	☐ Plan XVIII
Under age 65	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
Age 65 to 69	65,000	97,500	130,000	162,500	195,000	227,500	260,000	292,500	325,000
Age 70 and above	45,000	67,500	90,000	112,500	135,000	157,500	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:

☐ Plan I -- $5,000 for your spouse and $2,000 for each child

☐ Plan II -- $10,000 for your spouse and $ 4,000 for each child

☐ Plan III -- $15,000 for your spouse and $ 7,000 for each child

☐ 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**	**Date Eligible*** (MM/DD/YY)
			___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):
☐ Optional Life Insurance ☐ Dependent Life Insurance (spouse and/or child)

You must mark ONE of the following statements:

☐ The benefits have been explained to me, and I decline to participate.

☐ 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

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 _____

WHITE PEIA PINK Payroll Location GOLD Enrollee PEIA 1010 Revised November 2002

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

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.

MINNESOTA LIFE

GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY

Minnesota Life Insurance Company • 400 Tracy Way • Suite 100 • Charleston WV 25311 • Fax 304-344-1221

POLICYHOLDER: PEIA POLICY NUMBER: 33227

EMPLOYER INFORMATION - (to be completed by Benefit Coordinator)

EMPLOYER NAME	ACCOUNT NUMBER	DATE OF EMPLOYMENT/ RETIREMENT	EMPLOYEE STATUS ☐ ACTIVE ☐ RETIRED EMPLOYEE

EMPLOYEE INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	EMAIL ADDRESS

STREET ADDRESS	CITY	STATE	ZIP CODE	EMPLOYEE ID

NAME OF ALL LIFE APPLICANTS	RELATIONSHIP/ COVERAGE TYPE	SOCIAL SECURITY NUMBER	CURRENT LIFE AMOUNT	NEW TOTAL AMOUNT	PLAN NUMBER	DATE OF BIRTH	GENDER	* DATE ELIGIBLE
	Employee Basic life							
	Employee Optional life							
	Spouse Optional life							
	Child Optional life							

*Date of marriage or adoption, if applicable.

HEALTH QUESTIONS

EMPLOYEE		SPOUSE		CHILDREN		EMPLOYEE		SPOUSE		
YES	NO	YES	NO	YES	NO	HEIGHT	WEIGHT	HEIGHT	WEIGHT	OCCUPATION
☐	☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐	☐					

1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
3. Have you ever been diagnosed as having AIDS, ARC, or any disorder of your immune system; or tested positive for the presence of the HIV virus or HIV virus antibodies?

If you answer yes to any question, give details including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment in the Additional Health Information Section on the second page or on a separate sheet of paper.

AUTHORIZATION

The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. If I do not revoke this authorization, it will be valid for 24 months from the date I sign it. A photocopy shall be as valid as the original. I have read this Authorization and the Consumer Privacy Notice on the second page and I understand that I can have copies.

EMPLOYEE SIGNATURE	DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	DATE SIGNED
X			
SPOUSE SIGNATURE	**DAYTIME TELEPHONE NUMBER**	**EVENING TELEPHONE NUMBER**	**DATE SIGNED**
X			

03-30567.47 EdF64640 Rev 8-2006

Evidence of Insurability Application for Coverage

Employer Information – The benefit coordinator completes this section.

Employer name – The agency name as it appears on your PEIA monthly billing

Account number – The agency account number from your PEIA monthly billing

Date of employment/retirement – The employee's hire date or date the employee retired

Employee status – Mark whether an Active or Retired Employee

Stop. The rest of the form is for the employee to complete.

The employee only needs to complete the Spouse and Child information if he or she is applying for dependent life coverage.

The Evidence of Insurability Application must be mailed to Minnesota Life with the Basic or Optional Life and Dependent Life Insurance Enrollment Form.

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? ☐ Yes ☐ 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 ☐ Male ☐ 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? ☐ Yes ☐ 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	Policy number	Branch code	Coverage code
PEIA	**33227**		

Insured employee's name (last, first, middle initial)	Employee ID	Gender ☐ Male ☐ 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 ☐ Full time ☐ 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	Date
X	

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 **LB0**1 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

RET

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) ☐ M ☐ 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? ☐ Yes ☐ 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				
		SP	CH				
		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:

☐ Policyholder Only Health and Life (specify plan) _____

☐ Family Health and Life (specify plan) _____

☐ Life Insurance Only (NO health benefits)

☐ Life Insurance Only (health benefits under spouse's PEIA plan)

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:

☐ Extend my employer-paid insurance overage. *Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining accrued leave.*

☐ Increase my annuity amount (Complete proper forms from CPRB)

DEDUCTION AUTHORITY

☐ I authorize annuity deduction for any required premium beginning immediately after my earned extended coverage ends.

☐ I authorize annuity deduction for any required premium. I am not using leave credit for insurance.

☐ 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: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ 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:

To Be Completed By The Employer:

AGENCY

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) 3-1/3 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)
2. Step-child
3. Grandchild
4. Court-Ordered Dependent Child
5. Student(age19-25)
6. 0ther

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

ROL

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

RETIREE

Name (Last)	(First)	(MI)	(Generation)	Social Security Number
Sex (Mark One) ☐ Male ☐ 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	☐ Plan I	☐ Plan II	☐ Plan III	☐ Plan IV	☐ Plan V
Under age 65	$5,000	$10,000	$15,000	$20,000	$30,000
Age 65 to 69	3,250	6,500	9,750	13,000	19,500
Age 70 and above	2,500	5,000	7,500	10,000	15,000

Retiree's Age	☐ Plan VI	☐ Plan VII	☐ Plan VIII	☐ Plan IX	☐ Plan X
Under age 65	$40,000	$50,000	$75,000	$100,000	$150,000
Age 65 to 69	26,000	32,500	48,750	65,000	97,500
Age 70 and above	20,000	25,000	37,500	50,000	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:

☐ Plan I -- $ 5,000 for your spouse and $ 2,000 for each child
☐ Plan II -- $10,000 for your spouse and $ 4,000 for each child
☐ Plan III -- $ 15,000 for your spouse and $ 7,000 for each child
☐ 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	Date Eligible* (mm/dd/yyyy)
			___ 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 Deduction Authority - I am enrolling for (Mark all that apply):

☐ Optional Life Insurance ☐ Dependent Life Insurance (spouse and/or child)

You must mark ONE of the following statements:

☐ The benefits have been explained to me, and I decline to participate.

☐ 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.

Retired Employee's Signature: _____ Date:_____

AFFIDAVIT

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: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ 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:_____

AGENCY

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:_____

WHITE--PEIA PINK--Payroll Location GOLD--Enrollee PEIA 1010

Revised January 8, 2004

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

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".

SURVIVING DEPENDENT

Name (Last)	(First)	(MI)	(Generation)	
Sex (Circle One) M F	Date of Birth (MM/DD/YY)	Social Security #	Have you previously been covered by PEIA? YES ☐ NO ☐	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 ☐

FAMILY INFORMATION

1) Were you recently covered by any other health benefits plan for a period of at least three (3) months? ☐ YES ☐ 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					
		SP	CH					
		SP	CH					

CATEGORY for Dependent Child(ren):
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 write (e.g., M1 for Male Child; F3 for Female Grandchild; F26 for Female Step-child/Student, etc.).

COVERAGE

Please indicate the benefit plan for which you are enrolling:

1	Single Survivor's Health Coverage (no dependents)
2	Family Survivor's Health Coverage

Please indicate the type of PEIA plan for which you are enrolling:

1	PEIA Indemnity Plan
2	Managed Care Plan (Indicate Plan Name Below:)

_____

Check Option if Applicable: HMO ☐ POS ☐

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:

AGENCY

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.

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: _____ Retiree 2: _____
(Signature) (Signature)

_____ _____
(Day) (Day)

8.24.98/trs

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 ☐ Savings ☐ 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