

Comprehensive Care Partnership (CCP) Program Enrollment Form

Policyholder Name: _____ Address: _____

PEIA ID Number: _____ Daytime Phone: _____

Insurance effective date: _____ E-mail: _____

To enroll online, go to **www.wvpeia.com** and click on the green **“Manage My Benefits”** button in the upper right corner, register on the site or use your existing credentials to log-in and choose your CCP. If you do not have online access, you may complete this form.

Covered Individuals – PPB Plan A, B & D <small>(Only individuals listed below will be enrolled)</small>	Date of Birth	Relationship to Policyholder (Self, Spouse, Child)	CCP Location Include Name of Facility and Provider ID Number
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____

I agree that the above-listed persons carried on my PEIA PPB Plan coverage will participate in the CCP program at the above-listed health care provider. I agree the above-listed person(s) will abide by the rules, policies and restrictions of the CCP program.

Policyholder signature: _____ Date: _____

Please return this form to: **Public Employees Insurance Agency, Attn: CCP, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345 or Fax to 1-877-233-4295.** Coverage in the CCP will be effective on the first day of the month following receipt of your enrollment form, if received before the 25th of the month.