



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".

Retiree Name (Last)	(First)	(MI)	(Generation)	Social Security Number
Gender (Mark One) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yyyy)		Home Phone
Street Address		City	State	Zip Code

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 an Evidence of Insurability 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	<input type="checkbox"/>	Plan 1	<input type="checkbox"/>	Plan 2	<input type="checkbox"/>	Plan 3	<input type="checkbox"/>	Plan 4	<input type="checkbox"/>	Plan 5
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	<input type="checkbox"/>	Plan 6	<input type="checkbox"/>	Plan 7	<input type="checkbox"/>	Plan 8	<input type="checkbox"/>	Plan 9	<input type="checkbox"/>	Plan 10
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 any time by filing a Change of Beneficiary 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, MI, Generation)	Address (Street Address, City, State, Zip Code)	Social Security Number	Relationship to the Insured	Distribution %

If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary in the "Distribution %" field. 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.

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Dependent Life Insurance -- You may choose to enroll for dependent life insurance for your spouse and/or children. If you choose a plan higher than what you have as an active employee, you must complete and attach a Evidence of Insurability Form, and be approved by the life insurance carrier. To enroll, check the box beside the amount of dependent life insurance you desire. 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 for each dependent to be covered.

- | | | |
|---|--|--|
| <input type="checkbox"/> Plan 1 -- \$ 5,000 for your spouse
and \$ 2,000 for each child | <input type="checkbox"/> Plan 2 -- \$ 10,000 for your spouse
and \$ 4,000 for each child | <input type="checkbox"/> Plan 4 -- \$ 20,000 for your spouse
and \$ 10,000 for each child |
| <input type="checkbox"/> Plan 3 -- \$ 15,000 for your spouse
and \$ 7,500 for each child | <input type="checkbox"/> Plan 5 -- \$ 40,000 for your spouse
and \$ 15,000 for each child | |

Dependent Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (mm/dd/yyyy)	Relationship to the Insured	Date Eligible* (mm/dd/yyyy)
			Wife Husband	
			Son Daughter	
			Other specify below**	

* Date of marriage or adoption, if applicable. To add a dependent to your health coverage, complete a Change-In- Status form.
 ** Must be an eligible dependent according to PEIA rules. See your Summary Plan Description for details. You must provide documentation proving eligibility for each dependent you wish to cover under your dependent life insurance policy. Please see the memo that accompanies this form for details.
 Specify relationship:

Selection, Acceptance and Deduction Authority - I am enrolling for (Mark all that apply):

- Optional Life Insurance for myself
 Dependent Life Insurance (spouse and/or children)

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 annuity until revoked by me in writing. I understand that the PEIA may change the types or levels of benefits or the amount of contribution.

Tobacco Affidavit

Please mark which members of the family use tobacco and sign the acceptance box below. If the policyholder is tobacco-free, you will receive a discount on the optional life insurance premium. 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

I hereby accept the life insurance elected on this form. 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.

Policyholder Signature: _____

Date: _____

Agency Information -- TO BE COMPLETED BY AGENCY BENEFIT COORDINATOR

Active Account Number

Retiree Account Number

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Agency Name (optional): _____

Last Date of Active Employment

Effective Date of Retirement

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Hire Date

Effective Date of Retiree Insurance Coverage

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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: _____