



Surviving Dependents - Health Benefits Enrollment Form

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".

SURVIVENTS	Name (Last) (First) (MI) (Generation)				
	Sex (Circle One) M F	Date of Birth (mm/dd/yyyy)	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. <input type="checkbox"/> YES <input type="checkbox"/>	
Signature: _____					

FAMILY INFORMATION	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).																																													
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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.).																																														

COVERAGE	Please, indicate the benefit plan for which you are enrolling:		Please indicate the type of PEIA plan for which you are enrolling:									
	<table border="1"> <tr> <td>1</td> <td>Single Survivor's Health Coverage (no dependents)</td> </tr> <tr> <td>2</td> <td>Family Survivor's Health Coverage</td> </tr> </table>	1	Single Survivor's Health Coverage (no dependents)	2	Family Survivor's Health Coverage		<table border="1"> <tr> <td>1</td> <td>PEIA PPB Plan <i>Not eligible for Plan B, C or D</i></td> </tr> <tr> <td>2</td> <td>Health Plan Check Option A <input type="checkbox"/> B <input type="checkbox"/></td> </tr> </table>	1	PEIA PPB Plan <i>Not eligible for Plan B, C or D</i>	2	Health Plan Check Option A <input type="checkbox"/> B <input type="checkbox"/>	
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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. I understand that upon re-marriage I will not be eligible for survivor coverage. Applicant's Signature: _____ Date: _____												

AFFIDAVITS	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. 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
	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. <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.
	Signature: _____ Date: _____

ACCEPTANCE	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 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. I understand that upon re-marriage I will not be eligible for survivor coverage. 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 understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I acknowledge by signing this form that WVPEIA or its agents have access to my medical records to check my tobacco use status.	
	Signature: _____	Date: _____

AGENCY	To Be Completed By The Employer:	
	Agency Name	Account Number
	Effective Date of Coverage	Termination Date of Deceased Employee's Coverage
	Coverage Code	
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: _____	