

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

TERM

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

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

TERMINATION REASON	Check Appropriate Box:	
	<input type="checkbox"/> 001	Resignation (If transferring to another PEIA-insured agency, please use the online transfer function in Manage My Benefits)
	<input type="checkbox"/> 002	Terminated for Misconduct (If an Administrative Appeal is being instituted, please complete the "ADMINISTRATIVE APPEAL" section of this form).
	<input type="checkbox"/> 003	Terminated involuntarily or by reduction in work force <input type="checkbox"/> I DO <input type="checkbox"/> I DO NOT accept the three (3) additional months of extended benefits
	<input type="checkbox"/> 004	Voluntarily cancel all coverage. Re-enrollment restrictions may apply.*** (To cancel health insurance only, use a change-in-status form.)
	<input type="checkbox"/> 005	Retirement
	<input type="checkbox"/> 006	Cancellation of Employee Optional Life Insurance ***
	<input type="checkbox"/> 007	Cancellation of Dependent Optional Life Insurance
	<input type="checkbox"/> 008	Deceased (Please enter date of death) _____
	<input type="checkbox"/> 009	Surviving dependent remarriage (Please enter date of marriage) _____
	<input type="checkbox"/> 010	Termination -- Policyholder unavailable for signature (for use by agency benefit coordinator only)
	<input type="checkbox"/> 011	Other (Please explain) _____
*** According to IRS regulations, IRS Section 125 Premium Conversion Plan participants cannot voluntarily terminate a benefit without a qualifying event. If you are a Section 125 participant and this action is being requested outside of the Section 125 open enrollment period, please state the qualifying event and attach documentation to support the event. Please refer to your Summary Plan Description for further details and a list of qualifying events.		
Policyholder Signature: _____ Date: _____		

ADMINISTRATIVE APPEAL	In the case of a termination for misconduct, you may have the right to an administrative appeal. If an administrative appeal is to be instituted, with your employer's approval, you may continue your coverage for 3 MONTHS after the end of the month in which you are removed from the payroll, as long as you continue to pay your "employee's share" of the monthly premium. If you lose the appeal, and have elected to continue your coverage for these additional months, you will be required to reimburse the total premium for the months during which you have continued your coverage. Please mark your choice:	
	<input type="checkbox"/> I elect to continue coverage during the administrative appeal, realizing fully that if my appeal is lost, I am responsible for reimbursing the entire premium to the agency or to the State of West Virginia. <input type="checkbox"/> I decline to continue coverage during the administrative appeal.	
Policyholder Signature: _____ Date: _____		

COBRA	Under Federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by Acordia National, the company which administers COBRA for PEIA. You will have a limited amount of time to elect continuation of coverage.	
	COBRA premiums include both the employer and employee share of the premium, as well as an administrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact Acordia National at 1-888-440-7342.	

To Be Completed By The Employer:

AGENCY	Account 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: _____					