

**ENROLLMENT FORM**  
Plan Year 2014  
July 1, 2013-June 30, 2014

STATE OF WEST VIRGINIA  
**Mountaineer Flexible Benefits**

PLEASE PRINT USING A BALLPOINT PEN. PRESS FIRMLY; THE LAST COPY IS YOURS.

**1**

|                       |  |   |                      |  |                |     |              |
|-----------------------|--|---|----------------------|--|----------------|-----|--------------|
| SOCIAL SECURITY #     |  | E-MAIL  |                      | TYPE OF FORM<br><input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CHANGE IN STATUS |                |     |              |
| LAST NAME             |  |   | FIRST NAME           |  |                | MI  |              |
| HOME ADDRESS (STREET) |  |   | CITY                 |  | STATE          | ZIP | HOME PHONE   |
| BIRTH DATE<br>/ /     | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE | <input type="checkbox"/> MARRIED<br><input type="checkbox"/> SINGLE | DATE EMPLOYED<br>/ / |  | EFFECTIVE DATE |     | OFFICE PHONE |

**INSTRUCTIONS**

- 2 WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?**
- New participants who want to enroll for the first time
  - Employees who want to add, change or cancel coverage of other benefits
  - **EXISTING BENEFITS NOT INDICATED ON THIS FORM WILL CONTINUE AS CURRENTLY ENROLLED.**
- HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:**
- **IMPORTANT:** If you want to add, change or cancel coverage, you must check the box beside the appropriate benefit in Section 3.
  - Indicate coverage levels and any other pertinent information.
  - If you select family coverage for any benefit, you must provide dependent information in Section 4.
- CHANGE IN STATUS**
- Include supporting documentation.
  - Must be requested within 60 days of status changing event.
  - List all dependents you want covered.

RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN APRIL 30, 2013.

**3 Mountaineer Flexible Benefits Tax-Free Benefits Paid by Employees**

IF YOU ENROLL IN A HEALTH SAVINGS ACCOUNT, YOU CANNOT ENROLL IN A MEDICAL SPENDING ACCOUNT, BUT MAY ENROLL IN A LIMITED-USE MEDICAL SPENDING ACCOUNT.

| KEEP COVERAGE            | ADD COVERAGE             | CHANGE COVERAGE          | CANCEL COVERAGE  | BENEFITS  | COST PER PAY PERIOD  |
|--------------------------|--------------------------|--------------------------|--|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <b>DELTA DENTAL</b> <input type="checkbox"/> Dental Assistance <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced<br><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse<br><input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family | If you select dependent coverage for dental, vision or hearing, you must complete the dependent information below. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>VISION CHOOSE ONE VISION OPTION:</b> <input type="checkbox"/> Full Service <input type="checkbox"/> Exam Plus<br><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family            |   |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>EPIC Hearing Service Plan</b><br><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse<br><input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family |   |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <b>LONG-TERM DISABILITY INCOME PLAN Employee Only</b><br><input type="checkbox"/> 50% of salary coverage <input type="checkbox"/> 70% of salary coverage  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <b>SHORT-TERM DISABILITY INCOME PLAN Employee Only</b>  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <b>MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT</b> Use cost per-pay-period from your Worksheet.<br>ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2014.  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b> Use cost per-pay-period from your Worksheet.<br><input type="checkbox"/> Married, filing separately <input type="checkbox"/> Married, filing jointly <input type="checkbox"/> Single, head of household ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2014.       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <b>LEGAL (Post-tax)</b>   |  |

**Health Savings Account (Additional forms required.)**

| KEEP COVERAGE                                    | ADD COVERAGE             | CHANGE COVERAGE          | CANCEL COVERAGE          | Select your HSA coverage type:   |
|--|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/>                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Individual (\$3,250 maximum 2014 PY)          |
|  |                          |                          |                          | <input type="checkbox"/> Family (\$6,450 maximum 2014 PY)              |
|  |                          |                          |                          | <input type="checkbox"/> Over 55 Catch-up (additional maximum \$1,000) |
| <b>Box #1</b> 2014 Plan Year Total Dollar Amount |                          |                          |                          |  |
| <b>Box #2</b> Number of Pay Periods ÷            |                          |                          |                          |  |
| <b>Box #3</b> Reduction Per Regular Pay Period = |                          |                          |                          |  |

**Limited-Use Medical Expense FSA**

| KEEP COVERAGE   | ADD COVERAGE             | CHANGE COVERAGE          | CANCEL COVERAGE          | SUBTOTAL                               | COST PER PAY PERIOD |
|---|--------------------------|--------------------------|--------------------------|--|---------------------|
| <input type="checkbox"/>                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                     |
| <b>Box #1</b> 2014 Plan Year Total Dollar Amount              |                          |                          |                          | <b>HSA</b>                             |                     |
| <b>Box #2</b> Number of Pay Periods ÷                         |                          |                          |                          | <b>Limited-Use Medical Expense FSA</b> |                     |
| <b>Box #3</b> Reduction Per Regular Pay Period =              |                          |                          |                          | <b>SUBTOTAL</b>                        |                     |
| <b>TOTAL PER PER PAY PERIOD ADMINISTRATIVE FEE (HSA only)</b> |                          |                          |                          |  |                     |
| <b>TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD</b>           |                          |                          |                          |  |                     |

**4 DEPENDENT INFORMATION (Use an additional sheet of paper as needed for additional dependents.)**

| DEPENDENT NAME | RELATIONSHIP | BIRTH DATE | SOCIAL SECURITY # | CHECK COVERAGE SELECTED |        |         |           |
|----------------|--------------|------------|-------------------|-------------------------|--------|---------|-----------|
|                |              |            |                   | DENTAL                  | VISION | HEARING | LEGAL     |
|                | SPOUSE       |            |                   |                         |        |         | Automatic |
|                |              |            |                   |                         |        |         | Automatic |
|                |              |            |                   |                         |        |         | Automatic |
|                |              |            |                   |                         |        |         | Automatic |

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FBMC, BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

TURN COMPLETED FORM INTO YOUR BENEFITS COORDINATOR NO LATER THAN APRIL 30, 2013.

**FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)**

FEIN# \_\_\_\_\_

AGENCY# & NAME \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_

NO. PAY DEDUCTIONS \_\_\_\_\_

GROSS ANNUAL SALARY \_\_\_\_\_

BENEFIT COORDINATOR SIGNATURE \_\_\_\_\_

BENEFIT COORDINATOR PHONE# ( ) \_\_\_\_\_

BENEFIT COORDINATOR FAX# ( ) \_\_\_\_\_

LOCATION TYPE  WVU  STATE AGENCIES, COLLEGES & UNIV  COUNTY BOARDS of EDUCATION/ SCHOOLS  OTHER

APPLICATIONS SHOULD BE MAILED TO FBMC TWICE EACH WEEK DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY MAY 7, 2013.

|                    |             |             |
|--------------------|-------------|-------------|
| EMPLOYEE SIGNATURE | DATE SIGNED | TIME SIGNED |
|--------------------|-------------|-------------|

**FBMC USE ONLY**

|            |              |         |         |               |
|------------|--------------|---------|---------|---------------|
| DATA ENTRY | VERIFICATION | SCANNED | INDEXED | SPECIAL NOTES |
|------------|--------------|---------|---------|---------------|