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Governor



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WV Toll-free: 1-888-680-7342 • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: [www.wvpeia.com](http://www.wvpeia.com)

Dear PEIA Policyholder:

There has been a change in PEIA's eligibility rules for children to age 26, and you have a dependent who may be affected by the change. Beginning July 1, 2012, PEIA is bound by certain rules set forth in the Patient Protection and Affordable Care Act (PPACA) that were not previously applicable.

The rule of concern, and the purpose of this letter, relates to eligibility for children to age 26. Previously, children who had other employer-sponsored health coverage in which they could be covered as a policyholder could not be covered by PEIA. In other words, if they were working and their employer offered health insurance, PEIA could not cover them under our plan. That rule went away as of July 1. You may now cover your child to age 26, regardless of other available coverage, marital status, student status or place of residence.

You are receiving this letter because the dependent shown below was removed from your coverage within the last year, and may now be eligible to be reenrolled for coverage:

**DEPENDENT NAME, UNIQUE ID, DOB**

If you wish to re-enroll this dependent, please complete the form on the back of this letter, keep a copy for your records, and return the form to: **PEIA Eligibility Section, 1900 Kanawha Blvd. E, Charleston, WV 25305**. You have a special enrollment period between now and October 31, 2012, to reenroll this dependent. If you do not reenroll this dependent in your special enrollment period, you will not be able to enroll this dependent until the next Open Enrollment period, with coverage effective on July 1, 2013, unless you have another qualifying event.

You are not required to reenroll this dependent, and if the addition of this dependent causes an increase in your health premium, you will be required to pay that increased premium. Since this change took effect on July 1, and we didn't notify you in advance, we are offering you the opportunity to re-enroll this dependent retroactively to July 1, 2012. You must tell us on the form whether you want coverage effective on the first day of the month following receipt of this form, or retroactive to July 1. Please note that retroactive coverage comes with retroactive premiums.

We regret any inconvenience this lack of notice may have caused. If you have questions, please contact PEIA's customer service unit at 1-888-680-7342.

Sincerely,

Some Lucky Staff Member

# PEIA Dependent Re-enrollment Form

## Special Enrollment Period ✨ August – October 2012

Please re-enroll the following child for coverage:

**DEPENDENT NAME, UNIQUE ID, DOB**

Dependent Address (if different from policyholder):

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I choose to add this child for:

- Health coverage
- Dependent Life Insurance (if previously covered under dependent life insurance)

I want coverage to begin:

- Retroactively on July 1, 2012. I understand that I will be required to pay any increased premiums retroactively, as well.
- On the first day of the month following submission of this form. Premiums changes, if any, will happen when coverage becomes effective.
- I do not wish to reenroll this dependent at this time. (You may add this child to your coverage at a later date subject to the rules and policies in force at that time.)

### Tobacco Affidavit

Please mark which members of the family use tobacco. If none of the people enrolled on your coverage uses tobacco, you will receive any available discount on your health and life insurance premiums.

Who uses tobacco:     Policyholder    Dependent (spouse and/or children)    No Tobacco Users

I certify that this information is correct, and agree that if this information changes, I will notify the plan of such change in writing. I acknowledge by signing this form that WVPEIA or its agents have access to my medical records to check my tobacco use status. I understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby authorize payroll deduction for any premium associated with the coverage I have chosen. I understand that PEIA may change the number of plans offered or the types, levels or costs of benefits. 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.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_