

Earl Ray Tomblin
Governor



Ted Cheatham
Director

WV Toll-free: 1-888-680-7342 • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.wvpeia.com

Dear Potential Policyholder:

You have received this packet because you are an existing employee who did not take any coverage with PEIA at the time you were initially eligible. During this open enrollment period, you have the following options:

1. You may add health insurance for yourself and your eligible dependents. You must complete the attached enrollment form and return it to your benefit coordinator no later than April 30, 2011. The coverage you select will be effective on July 1, 2011. You must provide documentation of eligibility for each dependent you're adding to your plan. There is a cover sheet included with this packet that should accompany your documentation.
2. You **must** enroll for Basic Life insurance in addition to your health coverage. Active employees cannot have health coverage without basic life insurance. The application is included in this packet, as well.
3. You may enroll for Optional and Dependent Life Insurance, but you must complete the Optional and Dependent Life Insurance Enrollment form and the Evidence of Insurability application for each person to be covered. Both forms are available on our website. Minnesota Life, PEIA's life insurance carrier, will determine, based on your medical conditions, whether to issue the coverage. If the coverage is issued, it will be effective on the first day of the month following approval of Minnesota Life.

Thank you for your interest in PEIA benefits. We look forward to serving your benefit needs.

Sincerely,

Your PEIA Enrollment Team

Public Employees Insurance Agency Open Enrollment Health Benefits Enrollment Form



Complete this form if you are an existing employee with no coverage from PEIA, or if you were covered as a dependent under your parents' plan and are now applying as a policyholder. Complete all sections of the form except "AGENCY."

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 ()
	Sex (Circle One) M F	Date of Birth (mm/dd/yyyy)	Other Insurance (Plan Name) If Any			
	Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES <input type="checkbox"/> NO <input type="checkbox"/>					

FAMILY INFORMATION	Is spouse currently insured by PEIA as a policyholder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter spouse's Social Security Number: _____							
	Please complete the following information for all dependents who will be covered under your plan:							
	Name Last, First, MI, Generation)	Address (If different from above)	Relationship (Circle One)		Sex/ Category	Birth Date	Social Security Number	Other Insurance (Plan Name)
	-----	-----	SP	CH				
	-----	-----	SP	CH				
	-----	-----	SP	CH				

CATEGORY for Dependent Child(ren): Relationship Code 1. Child (biological or adopted) 2. Step-child 3. Grandchild 4. Court-Ordered Dependent Child 5. Student (age 19-25) 6. Other In dependent column titled "Sex/Category", please include both gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). *If adding a dependent child other than your biological or adopted child, documentation is required showing legal guardianship of the child.*

COVERAGE	COVERAGE SELECTION (Select One) I am enrolling for:		Please indicate the plan in which you are enrolling by checking the box beside the plan option you choose:																															
	<table style="width: 100%;"> <tr> <td style="width: 20px; text-align: center;">1</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td>Employee Only</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Employee/Child(ren) Only</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Family</td> </tr> <tr> <td style="text-align: center;">4</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Family with Employee Spouse</td> </tr> </table>	1	<input type="checkbox"/>	Employee Only	2	<input type="checkbox"/>	Employee/Child(ren) Only	3	<input type="checkbox"/>	Family	4	<input type="checkbox"/>	Family with Employee Spouse	<table style="width: 100%;"> <tr> <td style="width: 20px; text-align: center;">1</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td>PEIA PPB Plan A</td> <td style="width: 20px; text-align: center;">4</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td>The Health Plan HMO Plan A</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>PEIA PPB Plan B</td> <td style="text-align: center;">5</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>The Health Plan HMO Plan B</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>PEIA PPB Plan C</td> <td colspan="3"></td> </tr> </table>				1	<input type="checkbox"/>	PEIA PPB Plan A	4	<input type="checkbox"/>	The Health Plan HMO Plan A	2	<input type="checkbox"/>	PEIA PPB Plan B	5	<input type="checkbox"/>	The Health Plan HMO Plan B	3	<input type="checkbox"/>	PEIA PPB Plan C		
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AFFIDAVITS	<p>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.</p> <p>Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children)</p> <p style="padding-left: 40px;"><input type="checkbox"/> No Tobacco Users within the last six (6) months</p>
	<p>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.</p> <p><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.</p>

ACCEPTANCE	<p>I hereby accept the 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 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. 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.</p>	
	Employee's Signature: _____	Date: _____

AGENCY	To Be Completed By The Employer:		Agency Name		Account Number	Date of Employment
	Hours Worked Weekly	Effective Date of Coverage	Index Code	Region	Coverage Code	
	I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employees Insurance Plan.					
Authorized Signature: _____					Date: _____	



Open Enrollment Basic Life Insurance Enrollment Form

Complete this form if you are an existing employee with no coverage from PEIA, or if you were covered as a dependent under your parents' plan and are now applying as a policyholder. Complete all sections of the form except "AGENCY."

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 ()	
	Sex (Circle One) M F		Date of Birth (mm/dd/yyyy)	
	Are you currently insured with PEIA health insurance benefits through your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide spouse's Social Security Number (SSN): _____			

BENEFICIARY	Please designate the beneficiary(ies) of this basic term life insurance policy in the space provided below. The life insurance amount will be distributed equally among all designated beneficiaries unless otherwise indicated. 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 beneficiary survives the employee, payment will be made in accordance with the terms of the policy. 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)		Beneficiary Address (Street, City, State, Zip)		Social Security #
	-----		-----		-----
	-----		-----		-----
	-----		-----		-----
		Relationship To Insured		Distribution % <i>Total must equal 100%</i>	

COVERAGE	<u>Decreasing Term Benefit For Active Employees</u>	
	The Basic Life Insurance offered by PEIA is decreasing term coverage, which means that the amount of life insurance decreases as you age. Here are the policy values for Active employees:	
	Employee under age 65	\$10,000
	Employee Age 65 but under 70	\$6,500
	Employee Age 70 and over	\$5,000

AFFIDAVIT	Tobacco Affidavit	
	Please mark which members of the family use tobacco and sign the acceptance box below. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your PEIA PPB Plan health coverage (if any) and optional 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	

ACCEPTANCE	I hereby accept the basic life insurance. 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.	
	Employee Signature: _____	Date: _____

To Be Completed By The Employer:

AGENCY	Agency Name		Account Number	Date of Employment	
	Hours Worked Weekly	Effective Date of Coverage	Index Code	Region	Coverage Code
	I hereby certify that this information is true and this applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.				
	Authorized Signature: _____			Date: _____	

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Open Enrollment Dependent Documentation

To: PEIA Eligibility Documentation Unit

From: _____ Date: _____
(employee's name)

Re: Last four digits of SSN

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Please mark the type of dependent you're adding and the documentation attached.

Dependent Being Added	Documentation Required
Spouse	Copy of valid marriage license or certificate
Biological child or stepchild	Copy of child's birth certificate
Adopted child	Copy of adoption papers
Other child for whom the policyholder is 100% financially responsible	Court-ordered guardianship papers.

I understand that PEIA cannot process my enrollment or change in enrollment for me or my dependents until these documents have been received.

Please send this cover sheet with your documents to the address below.