

**State of West Virginia ★ Public Employees Insurance Agency
Health Benefits Enrollment Form**

HEALTH

Complete this form to enroll for PEIA health insurance coverage. Complete all sections of the form except the last section, "AGENCY"

EMPLOYMENT	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"/>

If you do not wish to participate in any PEIA health coverage, please sign this box and return this form to your benefit coordinator. I decline to participate in the health coverage.
Signature: _____ Date: _____

Is spouse currently insured by PEIA as a policyholder? Yes No If YES, provide spouse's Social Security Number (SSN): _____
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				
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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, a notarized copy of documentation is required showing that the child is completely dependent upon the member for financial support.

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 border="1" style="width:100%;"> <tr><td>1</td><td><input type="checkbox"/></td><td>Employee Only</td></tr> <tr><td>2</td><td><input type="checkbox"/></td><td>Employee/Child(ren) Only</td></tr> <tr><td>3</td><td><input type="checkbox"/></td><td>Family</td></tr> <tr><td>4</td><td><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 border="1" style="width:100%;"> <tr><td>1</td><td><input type="checkbox"/></td><td>PEIA PPB Plan A</td></tr> <tr><td>2</td><td><input type="checkbox"/></td><td>PEIA PPB Plan B</td></tr> <tr><td>3</td><td><input type="checkbox"/></td><td>PEIA PPB Plan C</td></tr> </table>	1	<input type="checkbox"/>	PEIA PPB Plan A	2	<input type="checkbox"/>	PEIA PPB Plan B	3	<input type="checkbox"/>	PEIA PPB Plan C	<table border="1" style="width:100%;"> <tr><td>4</td><td><input type="checkbox"/></td><td>The Health Plan HMO Plan A</td></tr> <tr><td>5</td><td><input type="checkbox"/></td><td>The Health Plan HMO Plan B</td></tr> </table>	4	<input type="checkbox"/>	The Health Plan HMO Plan A	5	<input type="checkbox"/>	The Health Plan HMO Plan B
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Tobacco Affidavit
You must complete this affidavit. Please mark which members of the family use tobacco and sign the affidavit. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your health and life insurance premiums; to receive the discount, please mark the No Tobacco Users box and sign the affidavit. 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: Policyholder Dependent (spouse and/or children) No Tobacco Users within the last six (6) months

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.

Employee's Signature: _____ Date: _____

To Be Completed By The Employer:

AGENCY	Agency Name _____		Account Number _____		Date of Employment _____	
	Hours Worked Weekly _____		Effective Date of Coverage _____		Coverage Code _____	
	Index Code _____		Region _____			
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: _____		