

RETIREE ENROLLMENT FORM

Plan Year 2017

July 1, 2016 - June 30, 2017

INSTRUCTIONS

1 You do not need to complete the form if you wish to continue your current retiree benefits without changes. New retirees or surviving spouses must complete this application to enroll for coverage. However, if you enroll or make changes, mail the form to FBMC/Direct Bill, P.O. Box 10789, Tallahassee, FL 32302-2789 or, fax to 866-836-9943. Please complete the dependent information section if you select coverage that includes dependents.

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SOCIAL SECURITY #	EFFECTIVE DATE (First day of month)	<input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW RETIREE	Choose one: <input type="checkbox"/> Pay by check (includes TIAA-CREF)*
		<input type="checkbox"/> CONTINUE EXISTING COVERAGE <input type="checkbox"/> OTHER	<input type="checkbox"/> Deduct from CPRB Retirement check**
LAST NAME (RETIREE OR SURVIVING SPOUSE)		FIRST NAME (RETIREE OR SURVIVING SPOUSE)	
MAILING ADDRESS (STREET)			
CITY	STATE	ZIP	BIRTH DATE
HOME PHONE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SURVIVING SPOUSE	E-MAIL
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			

* If you choose to pay by check, you will receive premium coupons for you to mail in your monthly premium.

** If you choose deductions through CPRB, your check deduction will pay for the following month's premium. Example: June deduction will pay the July premium. You will receive premium coupons for you to mail in your monthly premium until CPRB deductions begin.

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Monthly Retiree Rates				
DELTA DENTAL	ROUTINE	ASSISTANCE	BASIC	ENHANCED
<input type="checkbox"/> Cancel Dental Coverage	<input type="checkbox"/> Retiree Only \$9.31 <input type="checkbox"/> Retiree & Children* \$18.67 <input type="checkbox"/> Retiree & Spouse* \$20.83 <input type="checkbox"/> Retiree & Family* \$30.24	<input type="checkbox"/> Retiree Only \$10.06 <input type="checkbox"/> Retiree & Children* \$20.17 <input type="checkbox"/> Retiree & Spouse* \$22.50 <input type="checkbox"/> Retiree & Family* \$32.66	<input type="checkbox"/> Retiree Only \$17.27 <input type="checkbox"/> Retiree & Children* \$34.58 <input type="checkbox"/> Retiree & Spouse* \$38.54 <input type="checkbox"/> Retiree & Family* \$55.89	<input type="checkbox"/> Retiree Only \$28.72 <input type="checkbox"/> Retiree & Children* \$57.44 <input type="checkbox"/> Retiree & Spouse* \$66.70 <input type="checkbox"/> Retiree & Family* \$95.28
METLIFE VISION	EXAM PLUS		FULL SERVICE	
<input type="checkbox"/> Cancel Vision Coverage	<input type="checkbox"/> Retiree Only \$1.15 <input type="checkbox"/> Retiree & Family* \$2.61		<input type="checkbox"/> Retiree Only \$6.67 <input type="checkbox"/> Retiree & Family* \$16.97	
EPIC HEARING SERVICE				
<input type="checkbox"/> Cancel Hearing Coverage	<input type="checkbox"/> Retiree Only \$1.75	<input type="checkbox"/> Retiree & Children* \$2.60	<input type="checkbox"/> Retiree & Spouse* \$3.56	<input type="checkbox"/> Retiree & Family* \$4.40
HYATT LEGAL				
<input type="checkbox"/> Cancel Legal Coverage	<input type="checkbox"/> Retiree & Family* \$15.50			

*IF YOU SELECT DEPENDENT COVERAGE FOR ANY OF THE BENEFITS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.

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DEPENDENT INFORMATION

USE AN ADDITIONAL SHEET OF PAPER AS NEEDED FOR ADDITIONAL DEPENDENTS.

DEPENDENT NAME	RELATIONSHIP	MALE/ FEMALE	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED			
					DENTAL	VISION	HEARING	LEGAL
	SPOUSE							

I hereby authorize the WV Consolidated Public Retirement Board to deduct my insurance premiums from my monthly benefit check and make any subsequent premium changes as directed. For Retirees who did not elect to have premiums deducted from CPRB: I agree to remit payment to FBMC Benefits Management.

RETIREE SIGNATURE	DATE SIGNED
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