

RETIREE ENROLLMENT FORM

Plan Year 2012

July 1, 2011-June 30, 2012

PLEASE PRINT USING A BALLPOINT PEN.

1	SOCIAL SECURITY #	EFFECTIVE DATE	Choose one: <input type="checkbox"/> Pay by check (includes TIAA-CREF) <input type="checkbox"/> Deduct from CPRB Retirement check		
	LAST NAME (RETIREE OR SURVIVING SPOUSE)		FIRST NAME (RETIREE OR SURVIVING SPOUSE)		MI
MAILING ADDRESS [STREET]					
CITY			STATE	ZIP	BIRTH DATE <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HOME PHONE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW/WIDOWER	E-MAIL		

INSTRUCTIONS

2 All retirees or surviving spouse must complete this application to enroll for coverage. Please complete the dependent information section if you select coverage that includes dependents. You do not need to complete the form if you wish to continue your current benefits without changes. However, if you choose to enroll or make changes, please mail the form to FBMC at P.O. Box 730 561, Ormond Beach, FL 32173-0561.

3 Indicate all benefits selections by entering the necessary information below. Dependent eligibility is limited to the same benefit categories and amounts selected by the Retiree. If you elect dependent coverage for any benefit, you must provide dependent information in Section 4 below.

MOUNTAINEER RETIREE BENEFITS

KEEP COVERAGE	CANCEL COVERAGE	ADD COVERAGE	BENEFITS			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DELTA DENTAL	CHOOSE ONE DENTAL OPTION: <input type="checkbox"/> Dental Assistance <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced		CHOOSE YOUR COVERAGE LEVEL: <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree & Spouse* <input type="checkbox"/> Retiree & Children* <input type="checkbox"/> Retiree & Family*
			MONTHLY RETIREE DELTA DENTAL RATES	Dental Assistance Retiree Only \$10.46 Retiree & Children \$20.97 Retiree & Spouse \$23.39 Retiree & Family \$33.95	Basic Retiree Only \$17.95 Retiree & Children \$35.95 Retiree & Spouse \$40.06 Retiree & Family \$58.10	Enhanced Retiree Only \$29.85 Retiree & Children \$59.71 Retiree & Spouse \$69.33 Retiree & Family \$99.04
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VISION	CHOOSE ONE VISION OPTION: <input type="checkbox"/> Full Service <input type="checkbox"/> Exam Plus		CHOOSE YOUR COVERAGE LEVEL: <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree & Family*
			MONTHLY RETIREE VISION SERVICE PLAN RATES	Full Service plan Retiree Only \$10.09 Retiree & Family \$24.53	Exam Plus plan Retiree Only \$1.69 Retiree & Family \$3.84	

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

DEPENDENT INFORMATION					
DEPENDENT NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED	
				DENTAL	VISION
	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 by FBMC. **Participants in the TIAA-CREF retirement plan:** I certify the preceding benefit elections are correct and agree to remit payment to FBMC.

RETIREE SIGNATURE	DATE SIGNED
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FBMC USE ONLY

EFFECTIVE DATE	CPRB	DIVISION
DATA ENTRY	VERIFICATION	INDEXED