HEALTH

State of West Virginia Public Employee Insurance Agency
Health Benefits Enrollment Form

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY."

This is a 2-page form. You must complete and submit both pages to enroll in the plan. If page 2 is not submitted with page 1, you will not be enrolled for health coverage.

Employee

Legal Name (Last)	(First)		(MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address		County of Residence		Home Telephone ( )
City	State	Zip		Work Telephone ( )
Physical Address				Sex (Circle one) M F
City	State	Zip		Date of Birth (mm/dd/yyyy)
Email Address:				

Dependent Information

If you need more space than what is provided below, please use a blank sheet of paper and attach it to this form.

If spouse is currently insured by PEIA as a policyholder, please enter their Social Security Number _____

Legal Name (Last, First, MI, Generation)	Address (if different from above)	Relationship	Sex	Birth Date	Social Security #

Coverage

Coverage Selection (Select One) I am enrolling for:

	Employee Only
	Employee/Child(ren) Only
	Family

Please indicate the plan in which you are enrolling by checking the box to the left of the plan option you choose:

	PEIA PPB Plan A
	PEIA PPB Plan B
	PEIA PPB Plan C
	PEIA PPB Plan D

	The Health Plan HMO Plan A
	The Health Plan HMO Plan B
	The Health Plan POS

Proceed to page 2. This form is not valid if page 2 is not completed and submitted.

Health Benefits Enrollment Form – Page 2

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY."

Affidavits

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 PEIA 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 (6) months

Spousal Surcharge Affidavit: For active employees of state agencies, colleges, universities and county boards of education, if enrolling for family coverage, please mark the box that identifies your spouse's insurance coverage status. If your spouse has employer-sponsored coverage available and remains on your PEIA coverage, you will be assessed a surcharge. Please mark the statement that applies to your spouse:

☐ My spouse does not have health coverage available through his/her employer; is not employed, has Medicare, Medicaid, or Tri-Care, or is retired. (No surcharge will be applied.)

☐ My spouse is employed by a PEIA-participating agency. (No surcharge will be applied.) Name of agency: _____

☐ My spouse has health coverage available through his/her employer. (I understand that if my spouse is on my PEIA health coverage, the monthly premium surcharge will be applied to my premium.)

Acceptance

Check a box to indicate whether you accept or decline coverage, then sign the form.

☐ I hereby accept the group coverage I have indicated above. I understand that PEIA may change the type 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 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, all of 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.

☐ I do not wish to participate in any PEIA Health Coverage. I decline to participate in PEIA Health Coverage.

Employee's Signature: _____ Date:_____

Agency

Agency Name	Account Number	Date of Employment
Hours worked Weekly	**Effective Date of Coverage**	**Index Code** **Coverage Code**

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature:_____ Date: _____