

**State of West Virginia Public Employee Insurance Agency
Optional Life Insurance and Dependent Life Insurance Enrollment Form**

OPT/DEP

Complete this form to enroll for Opt/Dep Life Insurance. Complete all sections of the form except "AGENCY"

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/yy)	

Optional Life	<p>**An asterisk beside the plan number means Guaranteed Issue for New Hires within their initial enrollment period.</p> <p>Optional Life Insurance- If you have enrolled in basic Life insurance you may choose to enroll for optional life for yourself. Your coverage is based on your selection and your age on the effective date of coverage. If you need additional space, please use a blank sheet of paper and attach it.</p>									
	Employee's Age	<input type="checkbox"/> Plan 1**	<input type="checkbox"/> Plan 2**	<input type="checkbox"/> Plan 3**	<input type="checkbox"/> Plan 4**	<input type="checkbox"/> Plan 5**	<input type="checkbox"/> Plan 6**	<input type="checkbox"/> Plan 7**	<input type="checkbox"/> Plan 8**	<input type="checkbox"/> Plan 9**
	Under Age 65	\$5,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$75,000	\$80,000
	Age 65 to 69	3,250	6,500	13,000	19,500	26,000	32,500	39,000	48,750	52,000
	Age 70 and	2,250	4,500	9,000	13,500	18,000	22,500	27,000	33,750	36,000
Employee's Age	<input type="checkbox"/> Plan 10**	<input type="checkbox"/> Plan 11	<input type="checkbox"/> Plan 12	<input type="checkbox"/> Plan 13	<input type="checkbox"/> Plan 14	<input type="checkbox"/> Plan 15	<input type="checkbox"/> Plan 16	<input type="checkbox"/> Plan 17	<input type="checkbox"/> Plan 18	
Under Age 65	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	\$350,000	\$400,000	\$450,000	\$500,000	
Age 65 to 69	65,000	97,500	130,000	162,500	195,000	227,500	260,000	292,500	325,000	
Age 70 and	45,000	67,500	90,000	112,500	135,000	157,500	180,000	202,500	225,000	
<p>PEIA no longer stores Beneficiary information.</p> <p>Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.</p>										

Dependent Life	Dependent Life Insurance - You may choose to enroll for dependent life for your spouse and/or children. The beneficiary of the dependent life insurance policy is the employee. To enroll for dependent life insurance, mark the plan of your choice and complete the following information.				
	<input type="checkbox"/> Plan 1 \$5,000 for your spouse \$2,000 for each child	<input type="checkbox"/> Plan 2 \$10,000 for your spouse \$4,000 for each child	<input type="checkbox"/> Plan 3 \$15,000 for your spouse \$7,500 for each child	<input type="checkbox"/> Plan 4 \$20,000 for your spouse \$10,000 for each child	<input type="checkbox"/> Plan 5 \$40,000 for your spouse \$15,000 for each child
	Dependent Legal Name (Last, First, MI, Generation)		Relationship to Insured	Social Security Number	Date of Birth (mm/dd/yy)

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:	<input type="checkbox"/> Policyholder	<input type="checkbox"/> Dependent (spouse and/or children)

Acceptance	<input type="checkbox"/> I hereby accept the Life Insurance. 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.	
	<input type="checkbox"/> I do not wish to participate in PEIA OPT/Dep Life Insurance. I decline to participate in OPT/Dep Life Insurance.	
Employee's Signature: _____		Date: _____

Agency	Agency Name	Account Number	Date of Employment	
	Hours worked Weekly	Effective Date of Coverage	OPT Plan code	Dep Plan 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 full-time employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.			
Authorized Signature : _____			Date: _____	