BENEFITS TRAINING

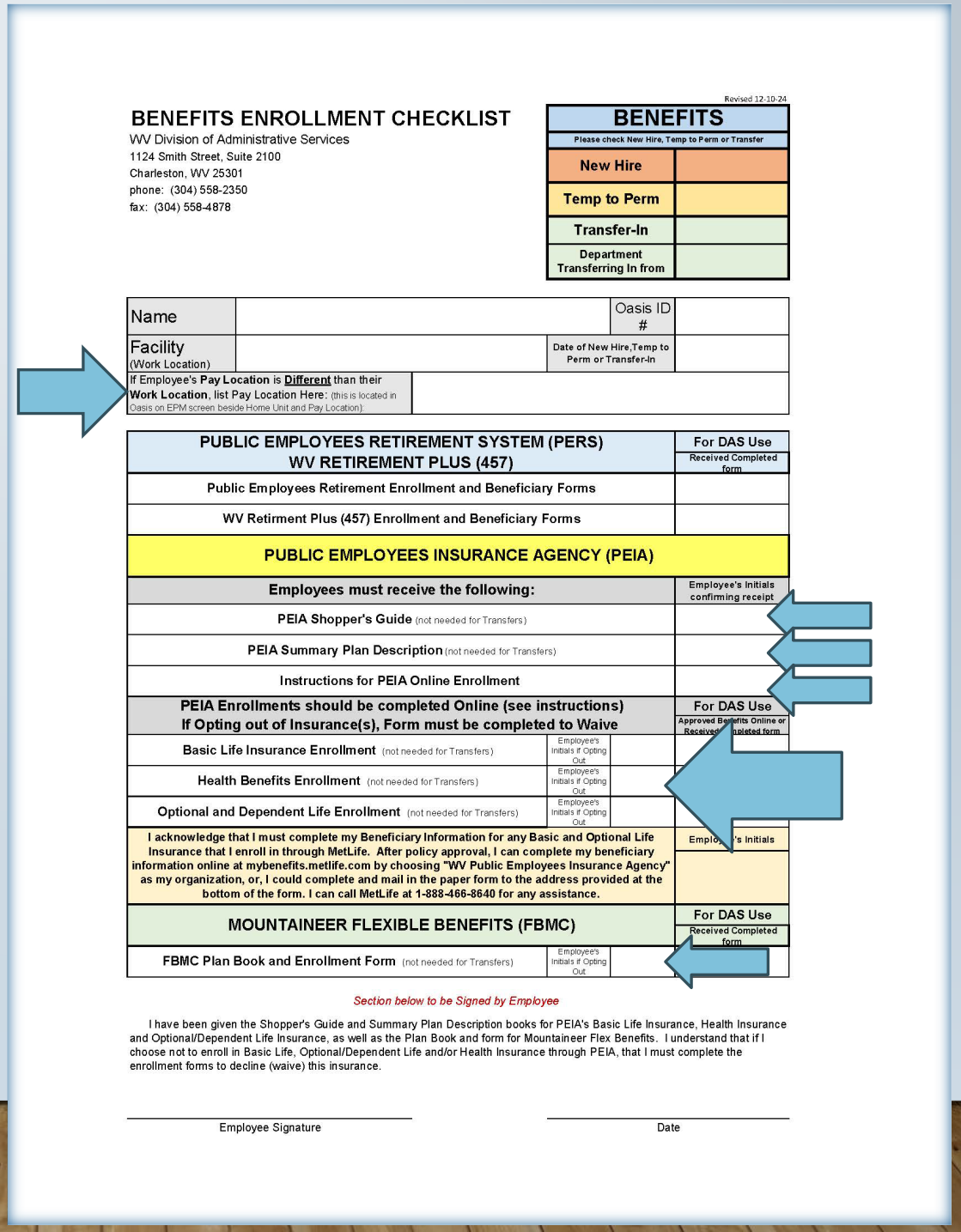
DIVISION OF ADMINISTRATIVE SERVICES

AGENDA

- Benefits Enrollment Checklist
- PERS (Retirement)
  - Enrollment Form
  - Beneficiary Form
- WV Retirement Plus 457
- PEIA (Benefits)
  - Online Enrollment
  - Divorce
  - MetLife (Life Insurance)
  - Mountaineer Flexible Benefits
    - Accident, Critical Illness, Hospital Insurance
    - Dental, Vision, Hearing, Legal
    - Short/Long-Term Disability
    - FSA and HSA Accounts
  - Self-Pay for PEIA/Mountaineer Flex
- Revive Health
- Employee Discounts
- Contact Info
- Questions

BENEFITS ENROLLMENT CHECKLIST

- ✓ **There is now one checklist for Benefits Enrollment. This revised form can be used for new hires, temp to perms and transfer-ins**
- ✓ **New section for employees who are paid from one location but physically work at another. Their insurance must be paid from the same facility they are paid from**
- ✓ **Employees must initial the form in the areas shown here with an arrow. If employee is <u>not</u> opting out of Basic Life, Health, Optional or Dependent Life insurance, those areas do not need initials**
- ✓ **Employee must sign and date this form**



Revised 12-10-24

BENEFITS ENROLLMENT CHECKLIST

WV Division of Administrative Services
1124 Smith Street, Suite 2100
Charleston, WV 25301
phone: (304) 558-2350
fax: (304) 558-4878

BENEFITS	
Please check New Hire, Temp to Perm or Transfer	
New Hire	
Temp to Perm	
Transfer-In	
Department Transferring In from	

Name		Oasis ID #	
Facility (Work Location)		Date of New Hire,Temp to Perm or Transfer-In	
If Employee's **Pay Location** is **Different** than their **Work Location**, list Pay Location Here: (this is located in Oasis on EPM screen beside Home Unit and Pay Location):			

PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS) WV RETIREMENT PLUS (457)	For DAS Use Received Completed form
Public Employees Retirement Enrollment and Beneficiary Forms	
WV Retirment Plus (457) Enrollment and Beneficiary Forms	

PUBLIC EMPLOYEES INSURANCE AGENCY (PEIA)			
Employees must receive the following:			Employee's Initials confirming receipt
PEIA Shopper's Guide (not needed for Transfers)			
PEIA Summary Plan Description (not needed for Transfers)			
Instructions for PEIA Online Enrollment			
PEIA Enrollments should be completed Online (see instructions) If Opting out of Insurance(s), Form must be completed to Waive			For DAS Use Approved Benefits Online or Received Completed form
Basic Life Insurance Enrollment (not needed for Transfers)	Employee's Initials if Opting Out		
Health Benefits Enrollment (not needed for Transfers)	Employee's Initials if Opting Out		
Optional and Dependent Life Enrollment (not needed for Transfers)	Employee's Initials if Opting Out		
I acknowledge that I must complete my Beneficiary Information for any Basic and Optional Life Insurance that I enroll in through MetLife. After policy approval, I can complete my beneficiary information online at mybenefits.metlife.com by choosing "WV Public Employees Insurance Agency" as my organization, or, I could complete and mail in the paper form to the address provided at the bottom of the form. I can call MetLife at 1-888-466-8640 for any assistance.			Employee's Initials
MOUNTAINEER FLEXIBLE BENEFITS (FBMC)			For DAS Use Received Completed form
FBMC Plan Book and Enrollment Form (not needed for Transfers)	Employee's Initials if Opting Out		

Section below to be Signed by Employee

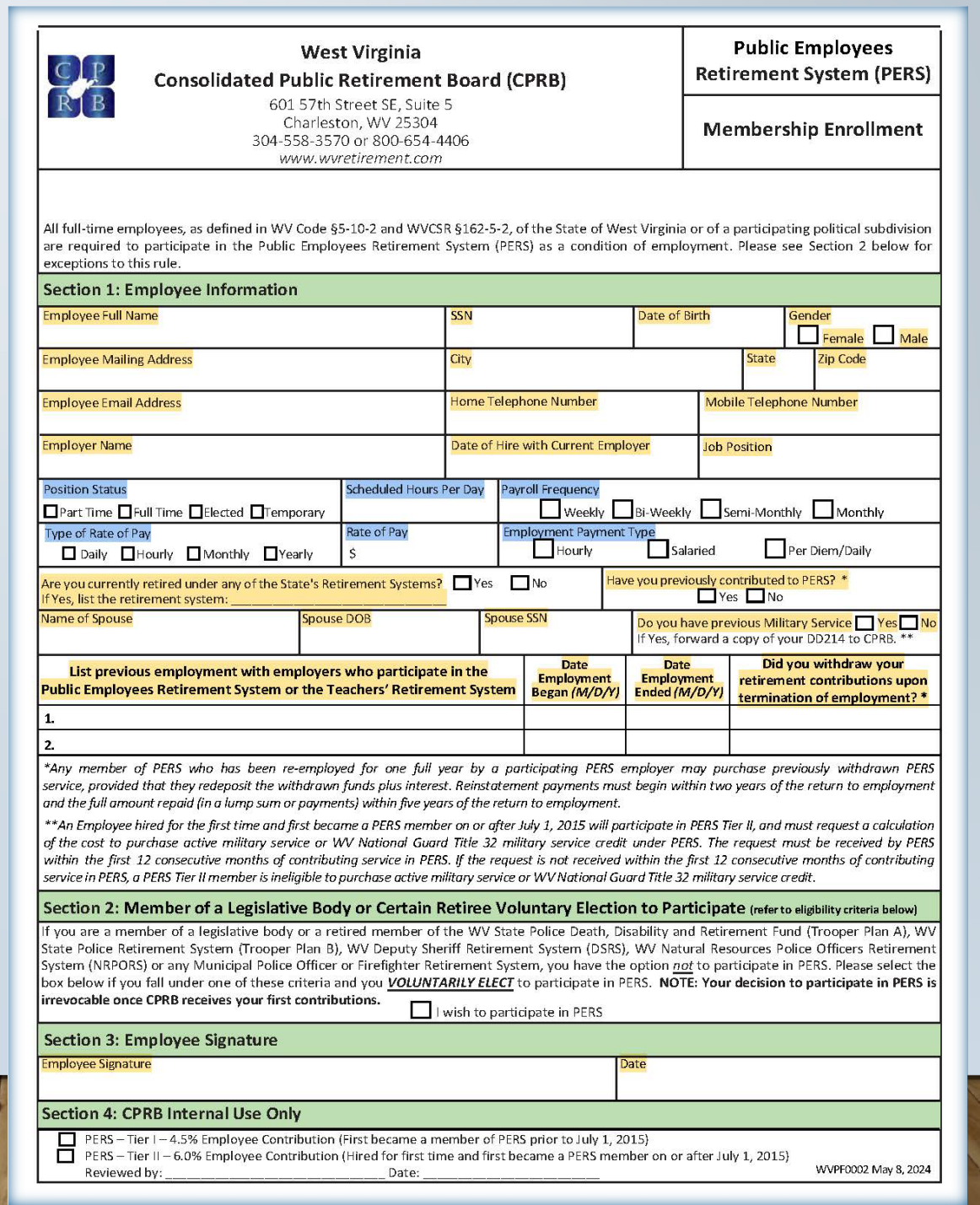
I have been given the Shopper's Guide and Summary Plan Description books for PEIA's Basic Life Insurance, Health Insurance and Optional/Dependent Life Insurance, as well as the Plan Book and form for Mountaineer Flex Benefits. I understand that if I choose not to enroll in Basic Life, Optional/Dependent Life and/or Health Insurance through PEIA, that I must complete the enrollment forms to decline (waive) this insurance.

Employee Signature _____ Date _____

PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS)

PERS
ENROLLMENT FORM

- **Enrollment form at www.wvretirement.com This deduction is mandatory**
- **PERS Tier I: Contributions are at 4.5% of gross salary if hired prior to 7/1/2015**
- **PERS Tier II: Contributions are at 6% of gross salary if hired after 7/1/2015**
- **Sections highlighted in yellow are filled out by employee and verified as completed by HR Facility Rep**
- **Sections highlighted in blue are filled out by HR facility Rep**
- **Original is mailed by HR Facility Rep to CPRB and a copy is submitted to DAS HR via request manager (along with Beneficiary Form)**



West Virginia
Consolidated Public Retirement Board (CPRB)
601 57th Street SE, Suite 5
Charleston, WV 25304
304-558-3570 or 800-654-4406
www.wvretirement.com

Public Employees Retirement System (PERS)

Membership Enrollment

All full-time employees, as defined in WV Code §5-10-2 and WVCSR §162-5-2, of the State of West Virginia or of a participating political subdivision are required to participate in the Public Employees Retirement System (PERS) as a condition of employment. Please see Section 2 below for exceptions to this rule.

Section 1: Employee Information

Employee Full Name | SSN | Date of Birth | Gender ☐ Female ☐ Male

Employee Mailing Address | City | State | Zip Code

Employee Email Address | Home Telephone Number | Mobile Telephone Number

Employer Name | Date of Hire with Current Employer | Job Position

Position Status ☐ Part Time ☐ Full Time ☐ Elected ☐ Temporary | Scheduled Hours Per Day | Payroll Frequency ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Type of Rate of Pay ☐ Daily ☐ Hourly ☐ Monthly ☐ Yearly | Rate of Pay $ | Employment Payment Type ☐ Hourly ☐ Salaried ☐ Per Diem/Daily

Are you currently retired under any of the State's Retirement Systems? ☐ Yes ☐ No
If Yes, list the retirement system: _____

Have you previously contributed to PERS? * ☐ Yes ☐ No

Name of Spouse | Spouse DOB | Spouse SSN

Do you have previous Military Service ☐ Yes ☐ No
If Yes, forward a copy of your DD214 to CPRB. **

List previous employment with employers who participate in the Public Employees Retirement System or the Teachers' Retirement System	Date Employment Began (M/D/Y)	Date Employment Ended (M/D/Y)	Did you withdraw your retirement contributions upon termination of employment? *
1.			
2.			

**Any member of PERS who has been re-employed for one full year by a participating PERS employer may purchase previously withdrawn PERS service, provided that they redeposit the withdrawn funds plus interest. Reinstatement payments must begin within two years of the return to employment and the full amount repaid (in a lump sum or payments) within five years of the return to employment.*

***An Employee hired for the first time and first became a PERS member on or after July 1, 2015 will participate in PERS Tier II, and must request a calculation of the cost to purchase active military service or WV National Guard Title 32 military service credit under PERS. The request must be received by PERS within the first 12 consecutive months of contributing service in PERS. If the request is not received within the first 12 consecutive months of contributing service in PERS, a PERS Tier II member is ineligible to purchase active military service or WV National Guard Title 32 military service credit.*

Section 2: Member of a Legislative Body or Certain Retiree Voluntary Election to Participate (refer to eligibility criteria below)

If you are a member of a legislative body or a retired member of the WV State Police Death, Disability and Retirement Fund (Trooper Plan A), WV State Police Retirement System (Trooper Plan B), WV Deputy Sheriff Retirement System (DSRS), WV Natural Resources Police Officers Retirement System (NRPORS) or any Municipal Police Officer or Firefighter Retirement System, you have the option *not* to participate in PERS. Please select the box below if you fall under one of these criteria and you ***VOLUNTARILY ELECT*** to participate in PERS. **NOTE: Your decision to participate in PERS is irrevocable once CPRB receives your first contributions.**

☐ I wish to participate in PERS

Section 3: Employee Signature

Employee Signature | Date

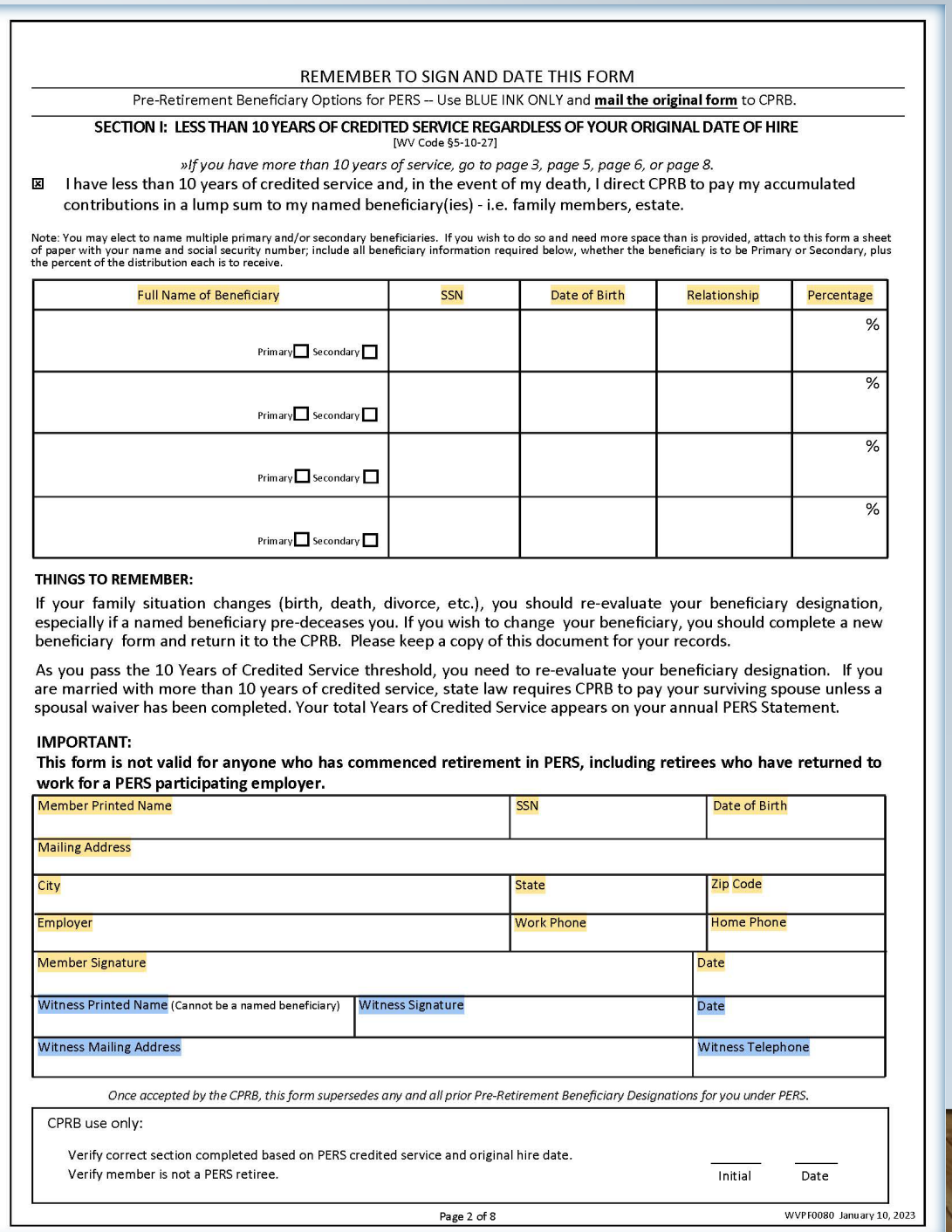
Section 4: CPRB Internal Use Only

☐ PERS – Tier I – 4.5% Employee Contribution (First became a member of PERS prior to July 1, 2015)
☐ PERS – Tier II – 6.0% Employee Contribution (Hired for first time and first became a PERS member on or after July 1, 2015)
Reviewed by: _____ Date: _____

WVPF0002 May 8, 2024

PERS
BENEFICIARY FORM

- **Must be in blue ink**
- **Page 2 for employee with < 10 years of service**
- **Page 3-8 for employee with > 10 years service**
- **Sections highlighted in yellow are filled out by employee and verified as completed by HR Facility Rep**
- **Sections highlighted in blue are filled out by HR Facility Rep. Witnessed date must match employee signature date**



REMEMBER TO SIGN AND DATE THIS FORM

Pre-Retirement Beneficiary Options for PERS -- Use BLUE INK ONLY and **mail the original form** to CPRB.

SECTION I: LESS THAN 10 YEARS OF CREDITED SERVICE REGARDLESS OF YOUR ORIGINAL DATE OF HIRE
[WV Code §5-10-27]

»If you have more than 10 years of service, go to page 3, page 5, page 6, or page 8.

☒ I have less than 10 years of credited service and, in the event of my death, I direct CPRB to pay my accumulated contributions in a lump sum to my named beneficiary(ies) - i.e. family members, estate.

Note: You may elect to name multiple primary and/or secondary beneficiaries. If you wish to do so and need more space than is provided, attach to this form a sheet of paper with your name and social security number; include all beneficiary information required below, whether the beneficiary is to be Primary or Secondary, plus the percent of the distribution each is to receive.

Full Name of Beneficiary	SSN	Date of Birth	Relationship	Percentage
Primary ☐ Secondary ☐				%
Primary ☐ Secondary ☐				%
Primary ☐ Secondary ☐				%
Primary ☐ Secondary ☐				%

THINGS TO REMEMBER:

If your family situation changes (birth, death, divorce, etc.), you should re-evaluate your beneficiary designation, especially if a named beneficiary pre-deceases you. If you wish to change your beneficiary, you should complete a new beneficiary form and return it to the CPRB. Please keep a copy of this document for your records.

As you pass the 10 Years of Credited Service threshold, you need to re-evaluate your beneficiary designation. If you are married with more than 10 years of credited service, state law requires CPRB to pay your surviving spouse unless a spousal waiver has been completed. Your total Years of Credited Service appears on your annual PERS Statement.

IMPORTANT:
This form is not valid for anyone who has commenced retirement in PERS, including retirees who have returned to work for a PERS participating employer.

Member Printed Name	SSN	Date of Birth
Mailing Address		
City	State	Zip Code
Employer	Work Phone	Home Phone
Member Signature		Date
Witness Printed Name (Cannot be a named beneficiary)	Witness Signature	Date
Witness Mailing Address		Witness Telephone

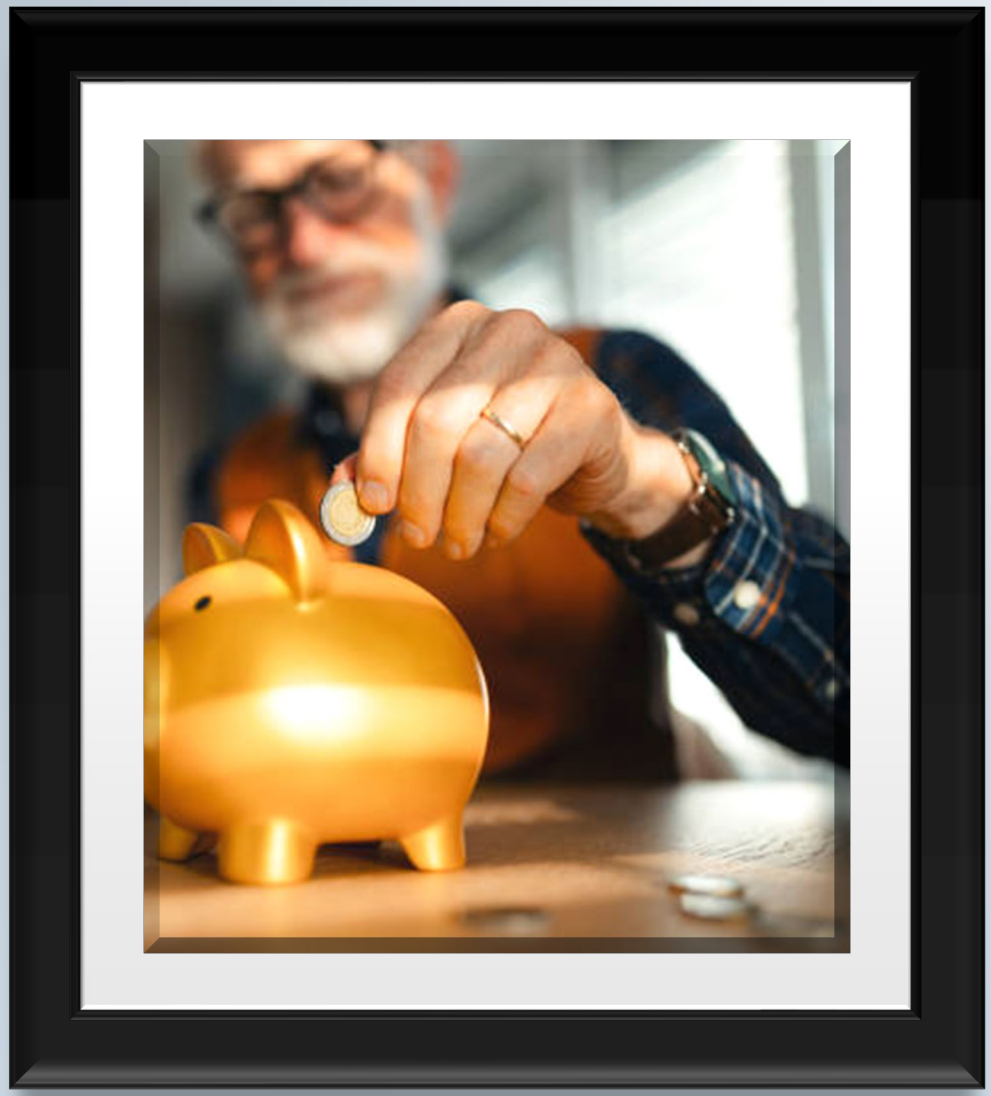
Once accepted by the CPRB, this form supersedes any and all prior Pre-Retirement Beneficiary Designations for you under PERS.

CPRB use only:

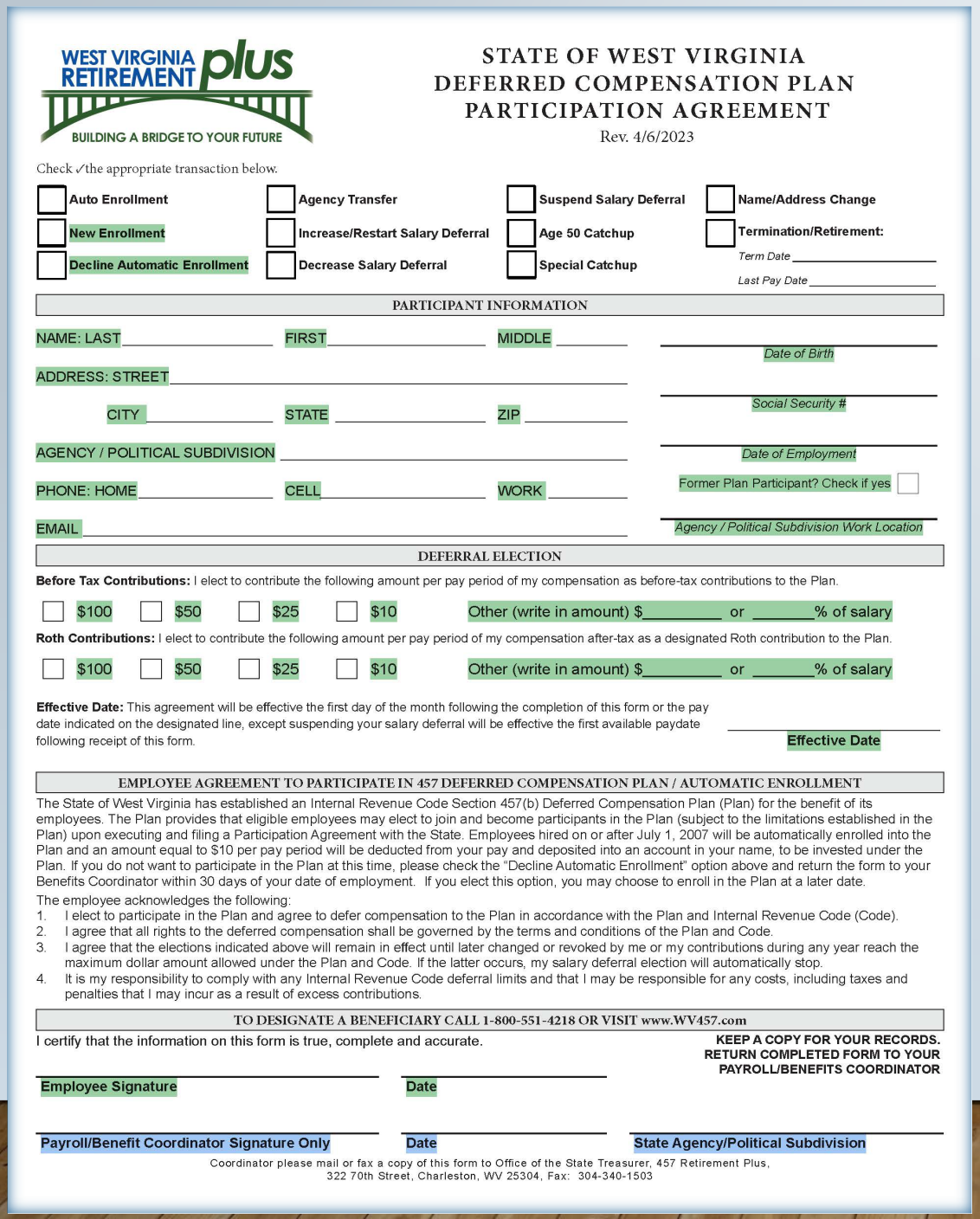
Verify correct section completed based on PERS credited service and original hire date. _____ Initial _____ Date

Verify member is not a PERS retiree.

Page 2 of 8 WVPF0080 January 10, 2023



WV RETIREMENT PLUS 457



WEST VIRGINIA RETIREMENT plus
BUILDING A BRIDGE TO YOUR FUTURE

STATE OF WEST VIRGINIA
DEFERRED COMPENSATION PLAN
PARTICIPATION AGREEMENT

Rev. 4/6/2023

Check ✓the appropriate transaction below.

☐ Auto Enrollment ☐ Agency Transfer ☐ Suspend Salary Deferral ☐ Name/Address Change
☐ New Enrollment ☐ Increase/Restart Salary Deferral ☐ Age 50 Catchup ☐ Termination/Retirement:
☐ Decline Automatic Enrollment ☐ Decrease Salary Deferral ☐ Special Catchup
Term Date _____
Last Pay Date _____

PARTICIPANT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____ _____ Date of Birth

ADDRESS: STREET _____ _____ Social Security #

CITY _____ STATE _____ ZIP _____ _____ Date of Employment

AGENCY / POLITICAL SUBDIVISION _____ Former Plan Participant? Check if yes ☐

PHONE: HOME _____ CELL _____ WORK _____ _____ Agency / Political Subdivision Work Location

EMAIL _____

DEFERRAL ELECTION

Before Tax Contributions: I elect to contribute the following amount per pay period of my compensation as before-tax contributions to the Plan.

☐ $100 ☐ $50 ☐ $25 ☐ $10 Other (write in amount) $_____ or _____% of salary

Roth Contributions: I elect to contribute the following amount per pay period of my compensation after-tax as a designated Roth contribution to the Plan.

☐ $100 ☐ $50 ☐ $25 ☐ $10 Other (write in amount) $_____ or _____% of salary

Effective Date: This agreement will be effective the first day of the month following the completion of this form or the pay date indicated on the designated line, except suspending your salary deferral will be effective the first available paydate following receipt of this form.

_____ Effective Date

EMPLOYEE AGREEMENT TO PARTICIPATE IN 457 DEFERRED COMPENSATION PLAN / AUTOMATIC ENROLLMENT

The State of West Virginia has established an Internal Revenue Code Section 457(b) Deferred Compensation Plan (Plan) for the benefit of its employees. The Plan provides that eligible employees may elect to join and become participants in the Plan (subject to the limitations established in the Plan) upon executing and filing a Participation Agreement with the State. Employees hired on or after July 1, 2007 will be automatically enrolled into the Plan and an amount equal to $10 per pay period will be deducted from your pay and deposited into an account in your name, to be invested under the Plan. If you do not want to participate in the Plan at this time, please check the "Decline Automatic Enrollment" option above and return the form to your Benefits Coordinator within 30 days of your date of employment. If you elect this option, you may choose to enroll in the Plan at a later date.

The employee acknowledges the following:

1. I elect to participate in the Plan and agree to defer compensation to the Plan in accordance with the Plan and Internal Revenue Code (Code).
2. I agree that all rights to the deferred compensation shall be governed by the terms and conditions of the Plan and Code.
3. I agree that the elections indicated above will remain in effect until later changed or revoked by me or my contributions during any year reach the maximum dollar amount allowed under the Plan and Code. If the latter occurs, my salary deferral election will automatically stop.
4. It is my responsibility to comply with any Internal Revenue Code deferral limits and that I may be responsible for any costs, including taxes and penalties that I may incur as a result of excess contributions.

TO DESIGNATE A BENEFICIARY CALL 1-800-551-4218 OR VISIT www.WV457.com

I certify that the information on this form is true, complete and accurate.

KEEP A COPY FOR YOUR RECORDS. RETURN COMPLETED FORM TO YOUR PAYROLL/BENEFITS COORDINATOR

_____ Employee Signature _____ Date

_____ Payroll/Benefit Coordinator Signature Only _____ Date _____ State Agency/Political Subdivision

Coordinator please mail or fax a copy of this form to Office of the State Treasurer, 457 Retirement Plus, 322 70th Street, Charleston, WV 25304, Fax: 304-340-1503

- A 457 plan is designed to supplement an employee's pension, social security and other personal retirement savings
- The plan is similar to a 401k plan in structure except it is designed to complement a public employee's primary retirement plan
- Employee can manage their own account by choosing from a variety of investment options or schedule a free one-on-one meeting with their local advisors
- Enrollment is optional
- Must DECLINE out of this benefit if not enrolling, once eligible.
  - If DECLINING the benefit and no form is received indicating such, $10.00 will be automatically deducted from paycheck and enrollment will begin
- Eligibility is immediate to enroll following start date
- Those eligible are State employees, permanent part-time employees and temporary (leased) employees
- Contributions are automatically deducted from the employee's paycheck, and they have the choice to save before tax (traditional contributions) or after tax (Roth contributions)
- Enrollee's can choose to change, stop or restart contributions at any time
- Sections highlighted in green are filled out by employee and verified as completed by HR Facility Rep
- Section highlighted in blue is filled out by DAS
- Form is emailed to DAS HR via request manager, who will send to the Treasurer

PUBLIC EMPLOYEE INSURANCE AGENCY (PEIA)

https://peia.wv.gov/FAQ/Pages/Manage-My-Benefits-Instructions.aspx

WV.gov State Agency Directory | Online Services

Change Text Size Search this site

West Virginia
Public Employees Insurance Agency
Benefitting People Who Serve

Manage My Benefits

Members | Health Plans | Partners | Forms & Downloads | Wellness Tools | FAQ | Contact PEIA

Popular Resources
Enrollment Forms
Forms & Downloads
Wellness Tools
Prescription Drug Lists
see more

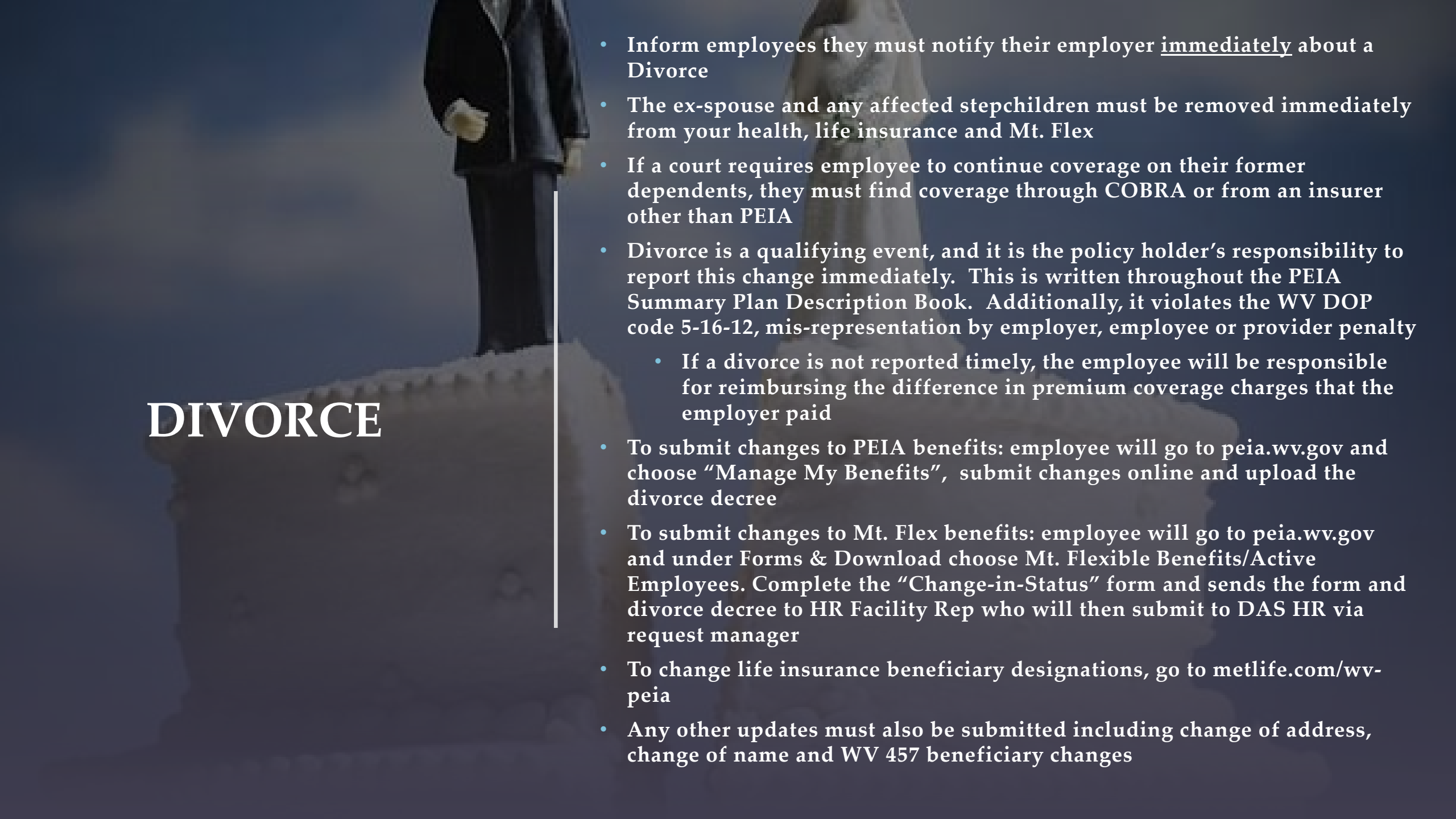
Questions?
Call: 1-888-680-7342
Email: peia.help@wv.gov

PEIA > FAQ > Manage My Benefits Instructions

Manage My Benefits Instructions

New Enrollment Instructions
How to Register as a Benefit Coordinator
How to Register as a Web Contributions Coordinator
How to Print a Credible Coverage Letter
How to request an ID card
How to Change Your Email Address
How to Upload Documents
How to Name or Change your Beneficiary
How to Update your Name

PEIA
ONLINE ENROLLMENT



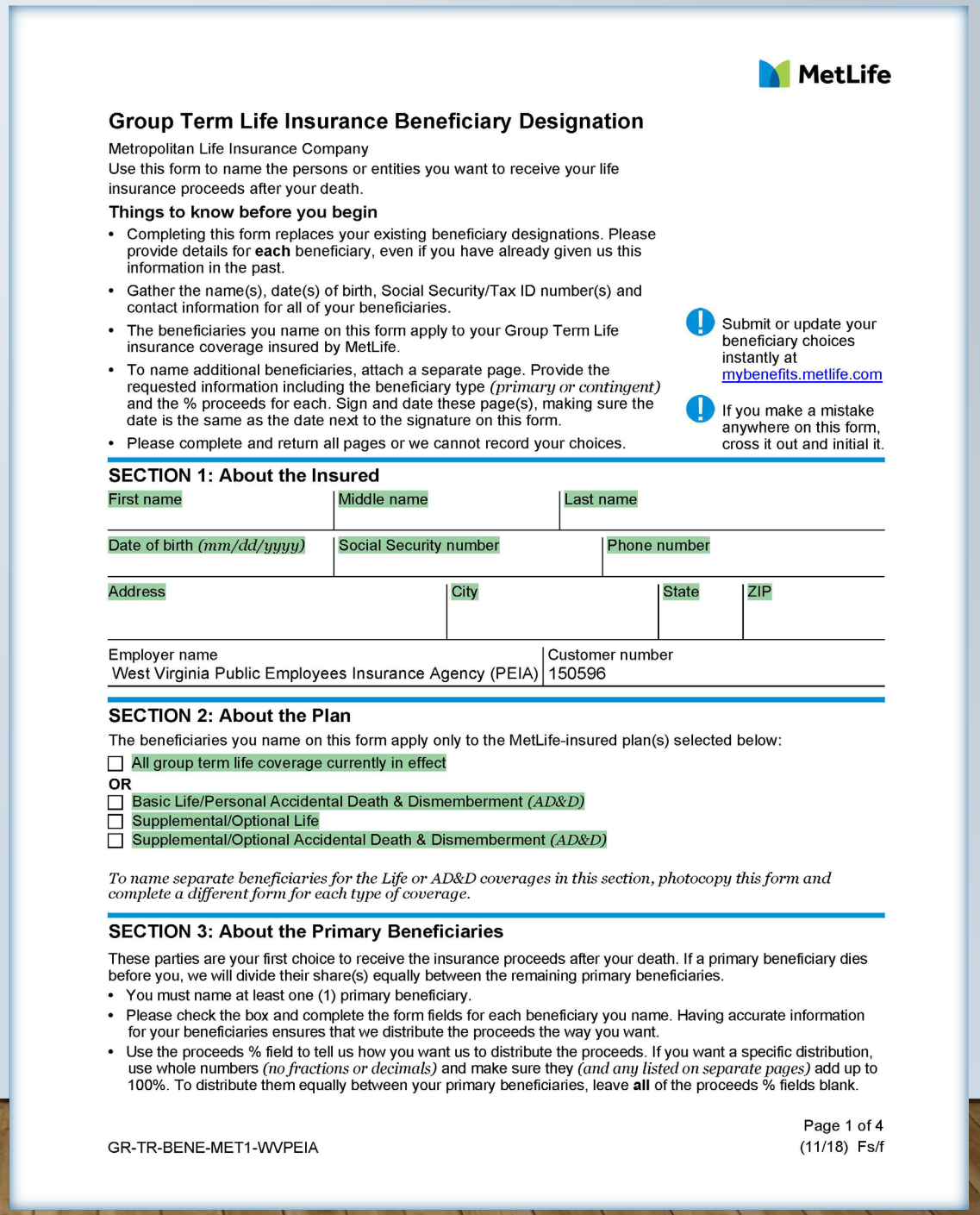
DIVORCE

- Inform employees they must notify their employer immediately about a Divorce
- The ex-spouse and any affected stepchildren must be removed immediately from your health, life insurance and Mt. Flex
- If a court requires employee to continue coverage on their former dependents, they must find coverage through COBRA or from an insurer other than PEIA
- Divorce is a qualifying event, and it is the policy holder's responsibility to report this change immediately. This is written throughout the PEIA Summary Plan Description Book. Additionally, it violates the WV DOP code 5-16-12, mis-representation by employer, employee or provider penalty
    - If a divorce is not reported timely, the employee will be responsible for reimbursing the difference in premium coverage charges that the employer paid
- To submit changes to PEIA benefits: employee will go to peia.wv.gov and choose "Manage My Benefits", submit changes online and upload the divorce decree
- To submit changes to Mt. Flex benefits: employee will go to peia.wv.gov and under Forms & Download choose Mt. Flexible Benefits/Active Employees. Complete the "Change-in-Status" form and sends the form and divorce decree to HR Facility Rep who will then submit to DAS HR via request manager
- To change life insurance beneficiary designations, go to metlife.com/wv-peia
- Any other updates must also be submitted including change of address, change of name and WV 457 beneficiary changes

METLIFE
LIFE INSURANCE BENEFITS
BENEFICIARY PAGE 1

Life Insurance – Free coverage for $10,000

- **$0 out-of-pocket to employee**
- **Sections highlighted in green are filled out by employee and verified as complete by HR Facility Rep**
- **Form is mailed to MetLife**
- **DAS HR does not get a copy**



MetLife

Group Term Life Insurance Beneficiary Designation

Metropolitan Life Insurance Company

Use this form to name the persons or entities you want to receive your life insurance proceeds after your death.

Things to know before you begin

- Completing this form replaces your existing beneficiary designations. Please provide details for **each** beneficiary, even if you have already given us this information in the past.
- Gather the name(s), date(s) of birth, Social Security/Tax ID number(s) and contact information for all of your beneficiaries.
- The beneficiaries you name on this form apply to your Group Term Life insurance coverage insured by MetLife.
- To name additional beneficiaries, attach a separate page. Provide the requested information including the beneficiary type *(primary or contingent)* and the % proceeds for each. Sign and date these page(s), making sure the date is the same as the date next to the signature on this form.
- Please complete and return all pages or we cannot record your choices.

Submit or update your beneficiary choices instantly at mybenefits.metlife.com

If you make a mistake anywhere on this form, cross it out and initial it.

SECTION 1: About the Insured

First name | Middle name | Last name

Date of birth *(mm/dd/yyyy)* | Social Security number | Phone number

Address | City | State | ZIP

Employer name: West Virginia Public Employees Insurance Agency (PEIA) | Customer number: 150596

SECTION 2: About the Plan

The beneficiaries you name on this form apply only to the MetLife-insured plan(s) selected below:

☐ All group term life coverage currently in effect

OR

☐ Basic Life/Personal Accidental Death & Dismemberment *(AD&D)*
☐ Supplemental/Optional Life
☐ Supplemental/Optional Accidental Death & Dismemberment *(AD&D)*

To name separate beneficiaries for the Life or AD&D coverages in this section, photocopy this form and complete a different form for each type of coverage.

SECTION 3: About the Primary Beneficiaries

These parties are your first choice to receive the insurance proceeds after your death. If a primary beneficiary dies before you, we will divide their share(s) equally between the remaining primary beneficiaries.

- You must name at least one (1) primary beneficiary.
- Please check the box and complete the form fields for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.
- Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers *(no fractions or decimals)* and make sure they *(and any listed on separate pages)* add up to 100%. To distribute them equally between your primary beneficiaries, leave **all** of the proceeds % fields blank.

Page 1 of 4

GR-TR-BENE-MET1-WVPEIA (11/18) Fs/f

METLIFE - BENEFICIARY PAGE 2-3

About the Primary Beneficiaries *(continued)*

☐ **Individual**

First name | Middle name | Last name

Address | Date of birth *(mm/dd/yyyy)*

City | State | ZIP

Gender ☐ M ☐ F | Social Security number | Phone number | Relationship to Insured

A Write in the % of proceeds assigned to this person _____%

☐ **Individual**

First name | Middle name | Last name

Address | Date of birth *(mm/dd/yyyy)*

City | State | ZIP

Gender ☐ M ☐ F | Social Security number | Phone number | Relationship to Insured

B Write in the % of proceeds assigned to this person _____%

☐ **Individual**

First name | Middle name | Last name

Address | Date of birth *(mm/dd/yyyy)*

City | State | ZIP

Gender ☐ M ☐ F | Social Security number | Phone number | Relationship to Insured

C Write in the % of proceeds assigned to this person _____%

☐ **Your Estate –** If you name your Estate as a primary beneficiary, you cannot name a contingent beneficiary. **D** Proceeds _____%

☐ **Testamentary Trust created in your Will –** The trust under your last Will and Testament as shall be admitted to probate. **E** Proceeds _____%

☐ **Living *(Inter Vivos)* Trust –** See further instructions on page 4. **F** Proceeds _____%

☐ **Charity/Organization –** List the charity or organization name and not an employee of the charity or organization. See further instructions on page 4. **G** Proceeds _____%

Total proceeds for all primary beneficiaries *(A-G plus any listed on separate pages)* must equal 100%. **100%**

SECTION 4: About the Contingent Beneficiaries

Skip this section if you're not naming a contingent beneficiary or if you named your Estate as a primary beneficiary. Contingent beneficiaries receive the insurance proceeds **only** if all of the primary beneficiaries are deceased at the time of your death. If a contingent beneficiary dies before you, we will divide their share(s) equally between the remaining contingent beneficiaries.

- Please check the box and complete the form fields for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.
- Do not list the same person or entity as both a primary and a contingent beneficiary.
- Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers *(no fractions or decimals)* and make sure they *(and any listed on separate pages)* add up to 100%. To distribute them equally between your contingent beneficiaries, leave **all** of the proceeds % fields blank.

☐ **Individual**

First name | Middle name | Last name

Address | Date of birth *(mm/dd/yyyy)*

City | State | ZIP

Gender ☐ M ☐ F | Social Security number | Phone number | Relationship to Insured

H Write in the % of proceeds assigned to this person _____%

☐ **Individual**

First name | Middle name | Last name

Address | Date of birth *(mm/dd/yyyy)*

City | State | ZIP

Gender ☐ M ☐ F | Social Security number | Phone number | Relationship to Insured

I Write in the % of proceeds assigned to this person _____%

☐ **Your Estate** **J** Proceeds _____%

☐ **Testamentary Trust created in your Will –** The trust under your last Will and Testament as shall be admitted to probate. **K** Proceeds _____%

☐ **Living *(Inter Vivos)* Trust –** See further instructions on page 4. **L** Proceeds _____%

☐ **Charity/Organization –** List the charity or organization name and not an employee of the charity or organization. See further instructions on page 4. **M** Proceeds _____%

Total proceeds for all contingent beneficiaries *(H-M plus any listed on separate pages)* must equal 100%. **100%**

METLIFE
BENEFICIARY PAGE 4

SECTION 5: About your Trust/Charity/Organization Beneficiaries

Skip this section if you did not name a Living Trust or Charity/Organization as one of your beneficiaries. Otherwise, please provide the information requested below on a separate page. Make sure you include the type of beneficiary *(primary or contingent)* and that you sign and date these page(s).

Please include:

- Trust/Charity/Organization name
- Address
- Phone number
- Type of Beneficiary *(primary or contingent)*
- % of proceeds you are assigning to the Trust/Charity/Organization

Additional information required for Living *(Inter Vivos)* Trust(s):

- Trust date
- Trust Tax ID number
- Trustee first, middle and last name

SECTION 6: Signature required

By signing below, I hereby revoke any previous designations, and I designate the person, people, or entity named herein as beneficiaries.

☐ Check if you are completing and signing this form as agent for the insured under a valid Power of Attorney.
Please submit a copy of the Power of Attorney with this beneficiary form.

Please print and sign below

Insured/Owner first name	Middle name	Last name

Sign Here	Insured/Owner signature	**Date form completed *(mm/dd/yyyy)***

STOP

Did you remember to…

- ✓ Provide complete information for each of your beneficiaries?
- ✓ Make sure the total "proceeds %" for your **primary beneficiaries** *(including those on a separate page)* equals 100%? Separately, did you remember to make sure the total "proceeds %" for your **contingent beneficiaries** *(including those on a separate page)* equals 100%?
- ✓ Complete, sign and date any extra pages that list beneficiary information *(such as Living Trust/Charity/Organization beneficiaries)*?
- ✓ Cross out and initial any mistakes you made? *(If you crossed out any answers, your signature is not enough. You must also initial all your corrections.)*

Example: ~~12/20/25~~ 12/20/15 *HM* ⇦ ***answer corrected, initials required***

Please note: we cannot record your beneficiary choices unless you complete these items.

SECTION 7: How to submit this form

Mail:
MetLife Recordkeeping & Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

Be sure to keep a copy of this completed form for your records.

MOUNTAINEER FLEXIBLE BENEFITS

Accident Insurance - Provides coverage if you are injured. Health plans may cover direct costs associated with an accident and accident insurance benefits can cover the unexpected costs, such as lost income, childcare, deductible and co-pays.

Critical Illness Insurance - Provides a payment following the diagnosis of a serious illness or disease.

Hospital Indemnity Insurance - Provides payment following admission of your hospital stay:

Benefits are payable for hospital stays due to:

- **Sickness**
- **Accidents, confinements due to an accident must be within 365 days (1 year) of the accident**
- **Routine pregnancy**
- **Complications of pregnancy**
- **Newborn complications**
- **Mental and nervous disorders**
- **Substance abuse**

MOUNTAINEER FLEXIBLE BENEFITS

SunLife – Dental

4 Plan Options - Assistance, Basic, Enhanced, and Premier

All plans cover 100% of in-network preventative dental services such as: oral evaluations, routine cleanings, and fluoride treatments for children under the age of 19. (refer to page 9 in the benefits guide)

Find a dentist - www.sunlife.com/findadentist or call 844 583-5036

Insurance Card – www.sunlife.com/wvpeia create an account and receive a confirmation email. Confirm the email, view your plan, and print a card.

Humana Eye Med – Vision

2 Plan Options – Exam Plus and Full Service

Both plans cover examinations, lenses, contact lenses, and frames. (refer to page 10 of the benefits guide)

Find a provider – www.humana.com or call 877 398-2980

Insurance card – download the mobile app

MOUNTAINEER FLEXIBLE BENEFITS

EPIC – Hearing

Expansive network with 7,000 hearing care professionals. Thousands of name- brands and private-labeled hearing aids from the industry's top brands.

3 in-person follow-up visits included after hearing aid purchase with a 60-day trial period.

Contacts – www.EPIChearing.com or call 866 956-5400 to discuss pricing, pay out-of-pocket costs, order hearing aids, discuss products and service options.

ARAG - Legal

2 Plan Options – Ultimate Advisor and Ultimate Advisor Plus

Legal protection and council for a wide range of covered services

Website: www.ARAGlegal.com/myinfo and enter access code 18387wv

MOUNTAINEER FLEXIBLE BENEFITS

Short-Term Disability (STD)

STD is 70% of your pre-disability earnings. This insurance is intended to cover you for a short period of time following a qualified illness, injury or pregnancy that keeps you out of work.

Once employee is off work for 30 days and exhausted all sick leave, the STD will start and pay up to 6 months (not to exceed payments of $1000 weekly).

Long-Term Disability (LTD)

LTD is similar to a STD but picks up at 6 months and will pay 50% or 60% of your pay until you are released to work by your physician, or until you turn 65, which ever comes first.

Plan Options

#1 Pays 50% and maximum monthly salary, can not be over $6,000

#2 Pays 60% and maximum monthly salary, can not be over $10,000

MOUNTAINEER FLEXIBLE BENEFITS

Flexible Spending Accounts (FSA) - **2 types of FSA's, Healthcare and Dependent Care. These accounts let you pay for eligible expenses with tax-free money.**

Healthcare FSA

By enrolling, it may help lower your taxable income. This account is used to pay for eligible medical expenses which are not covered by your insurance. For this option, your full amount is available at the beginning of the plan year, you don't have to wait for the money to accumulate. The minimum annual contribution is $150 and the maximum is $3,300.

Inspira debit card can be used to pay for healthcare expenses at merchants such as doctor's and dentist office, hospitals, pharmacies, hearing and vision care.

Eligible Expenses – register online at www.inspirafinancial.com to view list of covered expenses.

For more information on eligible expenses go to https://www.fsafeds.gov/support/eligibleexpenses

Dependent Care FSA

Your full amount is NOT available like the Healthcare option. Can be used for eligible school care, daytime baby-sitting fees, elder care services and nursery/preschool costs for children up to age 13. Expenses are paid out-of-pocket, then a claim form is submitted for the amount in your account.

- **Minimum contribution is $150 but the maximum varies depending on your tax filing status.**
- **Married filing separate $2,500**
- **Married filing jointly $5,000**
- **Single head of household $2,500**
- **If spouse is a full-time student with 1 dependent = $3,000, or 2 dependents = $5,000**

MOUNTAINEER FLEX BENEFITS

Health Savings Account (HSA)

This is a tax-free account to pay for qualified healthcare expenses and owned by you. If you leave your job, you can take it with you.

- ✓ **Funds are loaded onto your card as you contribute**
- ✓ **Funds do not have to be spent in the plan year they are deposited**
- ✓ **A one-time trustee to trustee transfer from an IRA account to your HSA**
- ✓ **Monthly custodian fee of $2.50**
- ✓ **Contribution limit is $4,300 for individual and $8,550 for family (established by the federal government and subject to change)**

To be eligible: Must have PEIA PPB Plan C or be covered by a high deductible health plan.

Covered Items: register online at www.inspirafinancial.com to view covered items such as copay for prescriptions, office visits, crutches, dental care, flu shots, hearing aides, wheelchair, x-rays etc.

MOUNTAINEER FLEXIBLE BENEFITS

Limited Purpose Flexible Spending Account (LPFSAs)

- **If you are enrolled in an HSA high-deductible health plan (Plan C) you can increase your savings with a Limited Expense Health Care FSA. This pre-tax benefit account helps you save on eligible out-of-pocket dental and vision care expenses while taking advantage of the long-term savings power of an HSA**
- **Funds are available on day one of the plan**
- **Minimum contribution is $150 and maximum is $3,300**
- **Coverage - For employee, spouse, qualifying child or qualifying relative for contact lenses, solutions, dental copay/deductible, dentures, bridges etc.**
- **More information provided by customer service at 844 729-3539**

MOUNTAINEER FLEXIBLE BENEFITS

Difference between a Flexible Spending Account and a Health Savings Account

FSA

FSA is a "use it or lose it" account, any money contributed to the account must be spent by the end of the plan year or it is forfeited to the employer.

FBMC allows a grace period through September 15th to spend the funds. The run-out period is by October 31st in which to submit a claim with supporting documentation.

HSA

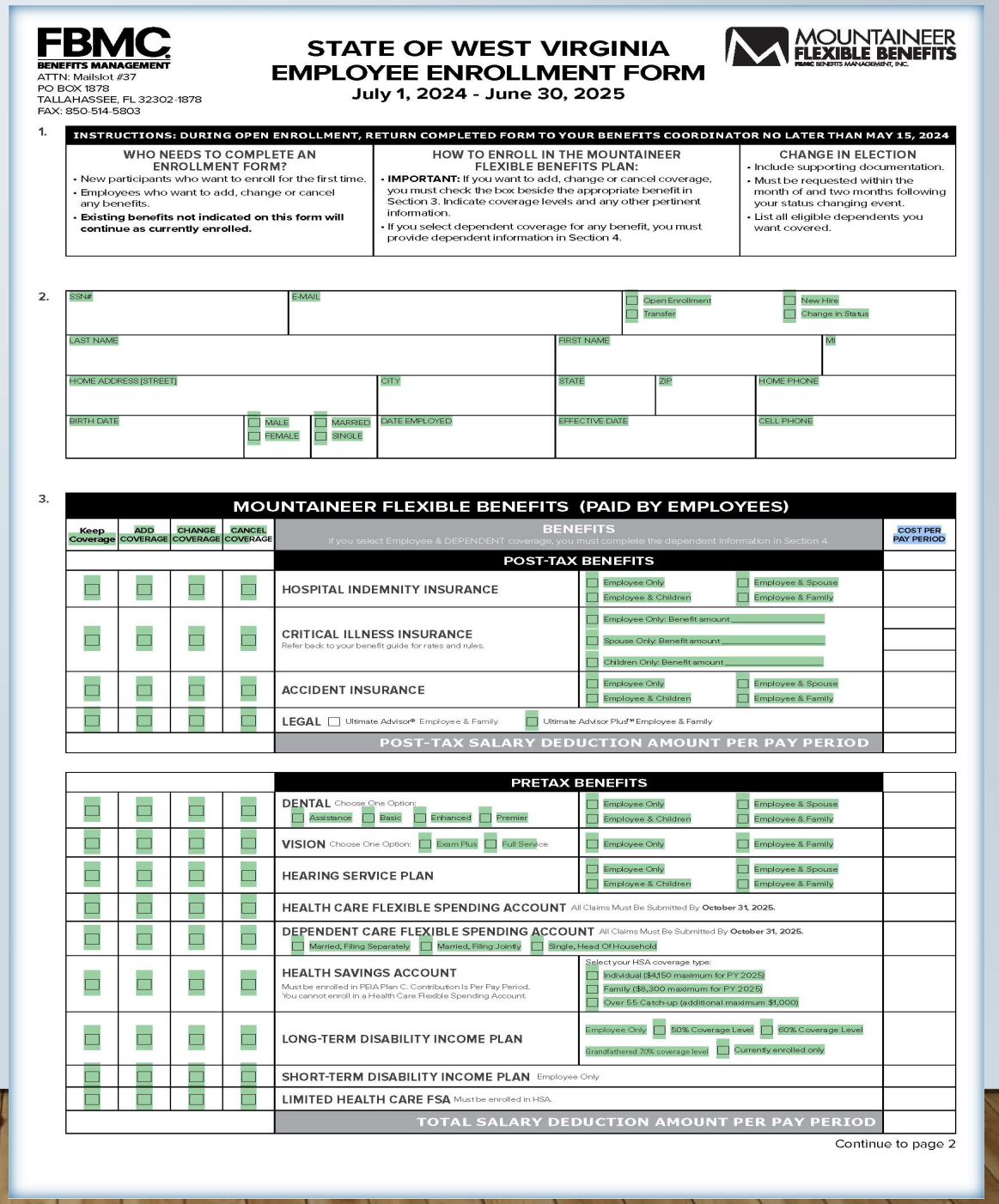
HSA is a "if you don't use it, you won't lose it" account. It is considered "self-owned", and funds will roll over year after year and are not forfeited.

Funds are loaded onto your card as you contribute per paycheck.

MOUNTAINEER FLEXIBLE BENEFITS

ENROLLMENT PAGE 1

- **Sections highlighted in green are filled out by employee and verified as complete by HR Facility Rep**
- **Form is submitted to DAS HR via request manager, who will fill in the blue sections and submit to FBMC**



FBMC BENEFITS MANAGEMENT
ATTN: Mailslot #37
PO BOX 1878
TALLAHASSEE, FL 32302-1878
FAX: 850-514-5803

STATE OF WEST VIRGINIA
EMPLOYEE ENROLLMENT FORM
July 1, 2024 - June 30, 2025

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

1.

INSTRUCTIONS: DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2024

WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?	HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:	CHANGE IN ELECTION
• New participants who want to enroll for the first time. • Employees who want to add, change or cancel any benefits. • **Existing benefits not indicated on this form will continue as currently enrolled.**	• **IMPORTANT:** If you want to add, change or cancel coverage, you must check the box beside the appropriate benefit in Section 3. Indicate coverage levels and any other pertinent information. • If you select dependent coverage for any benefit, you must provide dependent information in Section 4.	• Include supporting documentation. • Must be requested within the month of and two months following your status changing event. • List all eligible dependents you want covered.

2.

SSN#	EMAIL	☐ Open Enrollment ☐ Transfer	☐ New Hire ☐ Change in Status
LAST NAME	FIRST NAME	MI	
HOME ADDRESS [STREET]	CITY	STATE / ZIP	HOME PHONE
BIRTH DATE	☐ MALE ☐ FEMALE / ☐ MARRIED ☐ SINGLE	DATE EMPLOYED	EFFECTIVE DATE / CELL PHONE

3.

MOUNTAINEER FLEXIBLE BENEFITS (PAID BY EMPLOYEES)

Keep Coverage	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS (If you select Employee & DEPENDENT coverage, you must complete the dependent information in Section 4.)		COST PER PAY PERIOD
				POST-TAX BENEFITS		
☐	☐	☐	☐	HOSPITAL INDEMNITY INSURANCE	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	CRITICAL ILLNESS INSURANCE Refer back to your benefit guide for rates and rules.	☐ Employee Only: Benefit amount ☐ Spouse Only: Benefit amount ☐ Children Only: Benefit amount	
☐	☐	☐	☐	ACCIDENT INSURANCE	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	LEGAL ☐ Ultimate Advisor® Employee & Family ☐ Ultimate Advisor Plus™ Employee & Family		
				POST-TAX SALARY DEDUCTION AMOUNT PER PAY PERIOD		
				PRETAX BENEFITS		
☐	☐	☐	☐	DENTAL Choose One Option: ☐ Assistance ☐ Basic ☐ Enhanced ☐ Premier	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	VISION Choose One Option: ☐ Exam Plus ☐ Full Service	☐ Employee Only ☐ Employee & Family	
☐	☐	☐	☐	HEARING SERVICE PLAN	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	
☐	☐	☐	☐	HEALTH CARE FLEXIBLE SPENDING ACCOUNT All Claims Must Be Submitted By **October 31, 2025.**		
☐	☐	☐	☐	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT All Claims Must Be Submitted By **October 31, 2025.** ☐ Married, Filing Separately ☐ Married, Filing Jointly ☐ Single, Head Of Household		
☐	☐	☐	☐	HEALTH SAVINGS ACCOUNT Must be enrolled in PEIA Plan C. Contribution Is Per Pay Period. You cannot enroll in a Health Care Flexible Spending Account.	Select your HSA coverage type: ☐ Individual ($4,150 maximum for PY 2025) ☐ Family ($8,300 maximum for PY 2025) ☐ Over 55 Catch-up (additional maximum $1,000)	
☐	☐	☐	☐	LONG-TERM DISABILITY INCOME PLAN	Employee Only ☐ 50% Coverage Level ☐ 60% Coverage Level ☐ Grandfathered 70% coverage level ☐ Currently enrolled only	
☐	☐	☐	☐	SHORT-TERM DISABILITY INCOME PLAN Employee Only		
☐	☐	☐	☐	LIMITED HEALTH CARE FSA Must be enrolled in HSA.		
				TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD		

Continue to page 2

MOUNTAINEER FLEXIBLE BENEFITS

ENROLLMENT PAGE 2

FBMC BENEFITS MANAGEMENT
ATTN: Mailslot #37
PO BOX 1878
TALLAHASSEE, FL 32302-1878
FAX: 850-514-5803

STATE OF WEST VIRGINIA
EMPLOYEE ENROLLMENT FORM
July 1, 2024 - June 30, 2025

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

4

ELIGIBLE 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	ACCIDENT INSURANCE	CRITICAL ILLNESS	HOSPITAL INDEMNITY
	Spouse										

DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2024

I hereby authorize my Employer to reduce my gross salary by the total per pay period cost of the benefits selected above. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS PERMITTED BY THE PLAN AND THE IRS. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FBMC BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

DURING OPEN ENROLLMENT, GIVE COMPLETED FORMS TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2024.

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED

FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)

HSA EMPLOYEES MUST BE ENROLLED IN PEIA PLAN C OR ANOTHER ELIGIBLE HDHP.

AGENCY NAME _____

4 DIGIT WORK LOCATION # _____

EFFECTIVE DATE _____

NO. PAY DEDUCTIONS _____

GROSS ANNUAL SALARY _____

BENEFIT COORDINATOR SIGNATURE _____

SIGNATURE DATE _____

BENEFIT COORDINATOR PHONE# ( ) _____

BENEFIT COORDINATOR FAX# ( ) _____

ENROLLMENT FORMS SHOULD BE MAILED TO: **FBMC, PO BOX 1878,TALLAHASSEE, FL 32302-1878** DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY **MAY 15, 2024.**

BENEFITS Q & A

Q: **When is Open Enrollment?**

A: Around April 1 to May 15th. Changes to PEIA and Mt. Flex will be effective July 1. If there are no changes, benefits will continue as currently enrolled.

Q: **My address has changed, what do I need to do?**

A: Update information with 5 providers –

- FMBC – State of WV Active Employee Demographic Change Form
- PEIA – Change of Address Form
- PERS – Contact CPRB directly to change
- WV Retirement Plus 457 – Plan Form
- OASIS – Employee or their BC can go to ESS-Employee Self Service portal

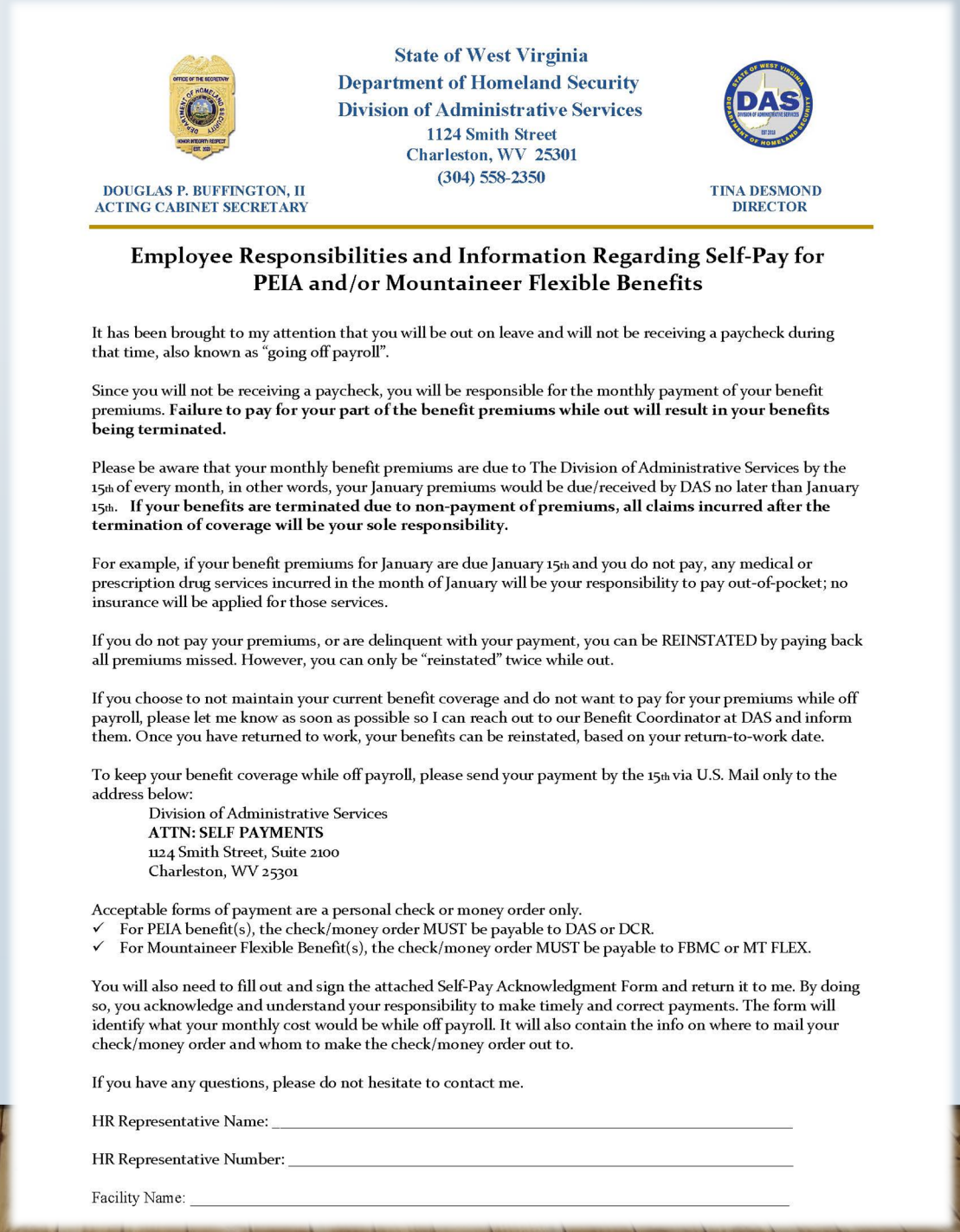
Q: **What is a qualifying event?**

A: Qualifying events are life events such as marriage, divorce, birth of a child, adoption, etc.

EMPLOYEE RESPONSIBILITIES FOR SELF-PAY

PEIA AND/OR MT FLEX BENEFITS

- **If employee goes off payroll, they are responsible for paying PEIA or Mt. Flex premiums for enrolled coverage.**
- **Failure to do so will result in their benefits being terminated.**



State of West Virginia
Department of Homeland Security
Division of Administrative Services
1124 Smith Street
Charleston, WV 25301
(304) 558-2350

DOUGLAS P. BUFFINGTON, II
ACTING CABINET SECRETARY

TINA DESMOND
DIRECTOR

Employee Responsibilities and Information Regarding Self-Pay for PEIA and/or Mountaineer Flexible Benefits

It has been brought to my attention that you will be out on leave and will not be receiving a paycheck during that time, also known as "going off payroll".

Since you will not be receiving a paycheck, you will be responsible for the monthly payment of your benefit premiums. **Failure to pay for your part of the benefit premiums while out will result in your benefits being terminated.**

Please be aware that your monthly benefit premiums are due to The Division of Administrative Services by the 15th of every month, in other words, your January premiums would be due/received by DAS no later than January 15th. **If your benefits are terminated due to non-payment of premiums, all claims incurred after the termination of coverage will be your sole responsibility.**

For example, if your benefit premiums for January are due January 15th and you do not pay, any medical or prescription drug services incurred in the month of January will be your responsibility to pay out-of-pocket; no insurance will be applied for those services.

If you do not pay your premiums, or are delinquent with your payment, you can be REINSTATED by paying back all premiums missed. However, you can only be "reinstated" twice while out.

If you choose to not maintain your current benefit coverage and do not want to pay for your premiums while off payroll, please let me know as soon as possible so I can reach out to our Benefit Coordinator at DAS and inform them. Once you have returned to work, your benefits can be reinstated, based on your return-to-work date.

To keep your benefit coverage while off payroll, please send your payment by the 15th via U.S. Mail only to the address below:

Division of Administrative Services
ATTN: SELF PAYMENTS
1124 Smith Street, Suite 2100
Charleston, WV 25301

Acceptable forms of payment are a personal check or money order only.
✓ For PEIA benefit(s), the check/money order MUST be payable to DAS or DCR.
✓ For Mountaineer Flexible Benefit(s), the check/money order MUST be payable to FBMC or MT FLEX.

You will also need to fill out and sign the attached Self-Pay Acknowledgment Form and return it to me. By doing so, you acknowledge and understand your responsibility to make timely and correct payments. The form will identify what your monthly cost would be while off payroll. It will also contain the info on where to mail your check/money order and whom to make the check/money order out to.

If you have any questions, please do not hesitate to contact me.

HR Representative Name: _____

HR Representative Number: _____

Facility Name: _____

SELF-PAY ACKNOWLEDGEMENT FORM

PEIA AND/OR MT FLEX BENEFITS

State of West Virginia
Department of Homeland Security
Division of Administrative Services
1124 Smith Street
Charleston, WV 25301
(304) 558-2350

DOUGLAS P. BUFFINGTON, II
ACTING CABINET SECRETARY

TINA DESMOND
DIRECTOR

Self-Pay Acknowledgement Form

I, _____ at Facility _____,
Printed First Name Last Name
hereby acknowledge that to maintain my current benefit coverage, I must pay all monthly premiums due by the 15th day of the month as described on page 1 "Employee Responsibilities and Information Regarding Self-Pay".

PEIA Insurance – Check or money order MUST be made payable to DAS or DCR

Monthly Premium Due $ _____

Mt. Flex Benefits – Check or money order MUST be made payable to FBMC or Mt. Flex

Monthly Premium Due $ _____

MAIL ALL PAYMENTS TO:
Division of Administrative Services
ATTN: SELF-PAYMENTS
1124 Smith Street, Suite 2100
Charleston, WV 25301

Employee Signature: _____ **Date:** _____

REVIVE HEALTH

REVIVE HEALTH
TELEHEALTH SERVICES

PEIA has partnered with ReviveHealth, formerly iSelectMD, as its preferred provider for telehealth services for PPB Plan members. Telehealth allows you to connect with a physician via phone or video chat when you have a non-emergent medical condition that needs treatment.

With just one simple phone call, members are connected to state-licensed, board-certified physicians who are ready to resolve non-emergency health issues 24 hours a day for a $10 copay. ReviveHealth physicians will take the time to listen and consult with you to recommend a treatment plan and, when appropriate, prescribe medication.

Physicians treat many non-emergent illnesses, for example:

- **Sinus Infections, Bronchitis, Cold & Flu, Sore Throat**
- **Ear Infections**
- **Urinary Tract Infections**
- **Gastroenteritis**
- **Pink Eye**

REVIVE HEALTH
TELEHEALTH SERVICES

Services

- **For consultation with a Board-Certified Physician call 1-844-433-8123. The access code is : *WV1144***
- **ReviveHealth is available anytime and anywhere you travel**
- **ReviveHealth encourages everyone to have a primary care physician and does not replace your existing primary care physician**
- **ReviveHealth requires a Medical History Disclosure to be completed prior to your first consultation. This may be completed online at http://www.revive.health/ or by calling customer care at 1-844-433-8123**
- **Depending on time of day or call volume, ReviveHealth physicians dedicate themselves to return calls within 30 minutes from the time they receive the request**

Prescriptions

- **ReviveHealth physicians reserve the right to write prescriptions when deemed appropriate and do not prescribe DEA controlled substances or certain other drugs that may be harmful due to potential abuse**

EMPLOYEE DISCOUNTS

STATE EMPLOYEE DISCOUNTS

- **AT&T and Verizon**
- **Dell Member Purchase Program**
- **Enterprise and Hertz Car Rental**
- **Hotels**
- **Planet Fitness**
- **WeSave Program**

More information can be found on DOP's website www.personnel.wv.gov and search for "Employee Discounts".

CONTACT INFORMATION

PEIA
Questions about the PEIA "PPB Plans" and eligibility for all plans.
Phone: 877 676-5573
Website: https://peia.wv.gov/
Susan (Jill) Beaty: susan.j.beaty@wv.gov or 304-352-0300 (For Shopper's Guide and Summary Books also available online)

The Health Plan
Questions about The Health Plan's benefits for HMO Plan A/B and POS
Phone: 800 624-6961 or 888 847-7902
Website: www.healthplan.org

MetLife
Questions about adding, changing or removing life insurance beneficiaries or filing a claim.
Phone: 888 466-8640
Website: https://online.metlife.com/edge/web/public/benefits enter WV PEIA

Revive Health
To learn more, visit http://www.revive.health/ or call 1-844-433-8123

CONTACT INFORMATION

Mountaineer Flexible Benefits
Phone: 844 559-8248 Customer Service
Website: www.myfbmc.com
Jodi Grady: jgrady@fbmc.com or 304-352-0311 (For plan books with forms)
Plan Books can be accessed online at peia.wv.gov

WV Retirement Plus 457 Plan
Andrew Wyne: Andrew.wyne@wvsto.gov or 304-341-0708 (For plan books)
Advisor, Catherine Preston: catherine.preston@empower.com or 304 904-1845
Advisor, Tammy Holstein: tammyholstein@empower.com or 304 539-6971

PERS
Phone: 304 558-3570
Email: CPRB@wv.gov

Legal Services
Phone 800 247-4184
Website www.araglegal.com/myinfo enter access code 18387wv

QUESTIONS OR COMMENTS?