DIVISION OF
ADMINISTRATIVE SERVICES

Human Resources Benefits Section

BENEFITS TEAM

- SHARON DUNBAR, SUPERVISOR

BENEFIT COORDINATORS

MARK BECKNER
CASEY DORSEY
LISA PAINTER
SUMMER STEPP

BENEFIT PACKET CONTENTS

- WV DAS cover page
- Consolidated Retirement Enrollment Form
- WV 457 Retirement Plus
- Securian Financial – 10K Certificate of Insurance
- Securian Financial – PEIA Group Term Life and AD & D
- PEIA – Shopper's Guide
- PEIA enrollment forms – Basic life, Health, Optional/Dependent Life
- Summary Plan Descriptions – Plan A, B, D and PPB Plan C
- Mountaineer Flexible Benefits (Dental, Vision, Hearing, Short Term Disability, Long Term Disability, etc.)
- WV State Credit Union info and enrollment
- WV SMART529 Education Plan

WV Division of Administrative Services

1124 Smith Street, 2nd Floor
Charleston, WV 25301
Phone: (304) 558-2350 Fax: (304) 558-4878

BENEFITS

New Hire

To Be Completed by Benefit Coordinator

NAME		Oasis ID #	
FACILITY		Temp to Perm Date	

Retirement / Pension (and Beneficiary Forms)	Check wvretirement.gov to see if employee is Tier 1 or 2	
	please circle one	
	1	2

WV Retirement Plus 457		Decline
Pre-tax (457PT)	After-tax (457AT)	Y or N
$	$	

Oasis Document # for PERS:	ENRL*
Oasis Document # for WV Retirement Plus 457:	MISC*

PEIA

	IRS Section 125	Y or N	Received Form	Waived/ Opt out of Insurance	PEIA load to Oasis	Benefit Coordinator Entered in Oasis	$ Amount	ENRL Document # if Benefit Coordinator entered in BA
Basic Life								ENRL*
Health								ENRL*
Optional Life								ENRL*
Dependent Life								ENRL*

MtFlex Benefits	
Employee add coverage	
$ Amount	
Oasis Document #	MISC*

MtFlex Legal (post tax)	
Employee add coverage	
$ Amount	
Oasis Document #	MFBLG*

To Be Completed by Employee

New Hire Checklist:

Retirement	
Public Employees Retirement Enrollment and Beneficiary Forms	
WV Retirment Plus (457) and Beneficiary Forms	
PEIA and FBMC Insurance	
PEIA Shopper's Guide, Summary Plan Description and Group Term Life Book	
Online Enrollment Instructions	
Basic Life Insurance Form	
Health Benefits Form	
Optional and Dependent Life Form	
FBMC Plan Book and Form	

I _____ have been given the instructions to go online to complete my Basic Life Insurance, Health Insurance and Optional/Depedent Life Insurance through PEIA, as well as the form to complete Mountaineer Flex Benefits. I understand that if I choose not to enroll in health insurance through PEIA, that I must complete the health enrollment form to decline (waive) insurance.

_____ Employee Signature

_____ Date

OASIS

Pay/Holiday Calendar 2022

Holidays

January 17	Martin Luther King Day
February 21	President's Day
May 10	Primary Election Day
May 30	Memorial Day
June 20	West Virginia Day
July 4	Independence Day
September 5	Labor Day
October 10	Columbus Day
November 8	General Election Day
November 11	Veteran's Day
November 24	Thanksgiving Day
November 25	Day After Thanksgiving
December 26	Christmas Day (Observed)

January

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

February

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

March

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

May

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

July

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

August

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

September

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

October

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

November

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

December

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Holidays
Pay Days

2022 HRM Payroll Pay Period Calendar			
Month	Pay Day	PP Begin	PP End
January	1/14/2022	12/18/2021	12/31/2021
	1/28/2022	1/1/2022	1/14/2022
February	2/11/2022	1/15/2022	1/28/2022
	2/25/2022	1/29/2022	2/11/2022
March	3/11/2022	2/12/2022	2/25/2022
	3/25/2022	2/26/2022	3/11/2022
April	4/8/2022	3/12/2022	3/25/2022
	4/22/2022	3/26/2022	4/8/2022
May	5/6/2022	4/9/2022	4/22/2022
	5/20/2022	4/23/2022	5/6/2022
June	6/3/2022	5/7/2022	5/20/2022
	6/17/2022	5/21/2022	6/3/2022
July	7/1/2022	6/4/2022	6/17/2022
	7/15/2022	6/18/2022	7/1/2022
	7/29/2022	7/2/2022	7/15/2022
August	8/12/2022	7/16/2022	7/29/2022
	8/26/2022	7/30/2022	8/12/2022
September	9/9/2022	8/13/2022	8/26/2022
	9/23/2022	8/27/2022	9/9/2022
October	10/7/2022	9/10/2022	9/23/2022
	10/21/2022	9/24/2022	10/7/2022
November	11/4/2022	10/8/2022	10/21/2022
	11/18/2022	10/22/2022	11/4/2022
December	12/2/2022	11/5/2022	11/18/2022
	12/16/2022	11/19/2022	12/2/2022
	12/30/2022	12/3/2022	12/16/2022
January 2023	1/13/2023	12/17/2022	12/30/2022

CONSOLIDATED PUBLIC RETIREMENT BOARD

Two levels of participation – PERS1 or PERS2

Only Permanent (Full-time) employees are eligible

PERS1 – Employees hired prior to July 1, 2015 – 4.5% of salary is withheld each pay period

PERS2 – Employees hired after July 1, 2015 – 6% of salary is withheld each pay period

West Virginia
Consolidated Public Retirement Board
Serving Those Who Serve West Virginia

Consolidated Public Retirement Board
4101 MacCorkle Avenue, SE
Charleston, WV 25304
304-558-3570 or 800-654-4406
www.wvretirement.com

Public Employees Retirement System (PERS) Enrollment Form

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: Please complete Sections 1 and 2 and return this form to CPRB.

Full Name | SSN | Date of Birth | Telephone Number

Gender ☐ Female ☐ Male | Member Mailing Address | City | State | Zip Code

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

Position Status ☐ Full Time ☐ Elected ☐ Part Time ☐ 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? ☐ No ☐ Yes
If Yes, please provide the employer:

Have you previously contributed to the Public Employees Retirement System? * ☐ No ☐ Yes

Name of Spouse | Spouse Date of Birth | Spouse SSN

Section 2: Voluntary Election to Participate: Please See Eligibility Criteria Below

IF YOU ARE AN ELECTED OFFICIAL OR A RETIRED MEMBER OF THE WV STATE POLICE DEATH, DISABILITY AND RETIREMENT SYSTEM (PLAN A), WV STATE POLICE RETIREMENT SYSTEM (PLAN B), WV DEPUTY SHERIFF RETIREMENT SYSTEM (DSRS), OR ANY MUNICIPAL POLICE OR FIREFIGHTER RETIREMENT SYSTEM, YOU HAVE THE OPTION TO ELECT *NOT* TO PARTICIPATE IN PERS.

Please select the box below if you fall under one of the above criteria and you *VOLUNTARILY ELECT* to participate in PERS.

NOTE: YOUR DECISION TO PARTICIPATE IN PERS IS IRREVOCABLE ONCE CPRB RECEIVES YOUR FIRST CONTRIBUTION.

☐ **I wish to participate in PERS**

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.			
3.			

**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.*

Signature _____ Date _____

Section 3: Internal CPRB 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)

CPRB Staff Name: _____ 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, charity.

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. Please call the CPRB when this time occurs. 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) Facility Benefits Coordinator Name	Witness Signature Benefits Coordinator	Date
Witness Mailing Address Facility Address		Witness Telephone Facility Telephone

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

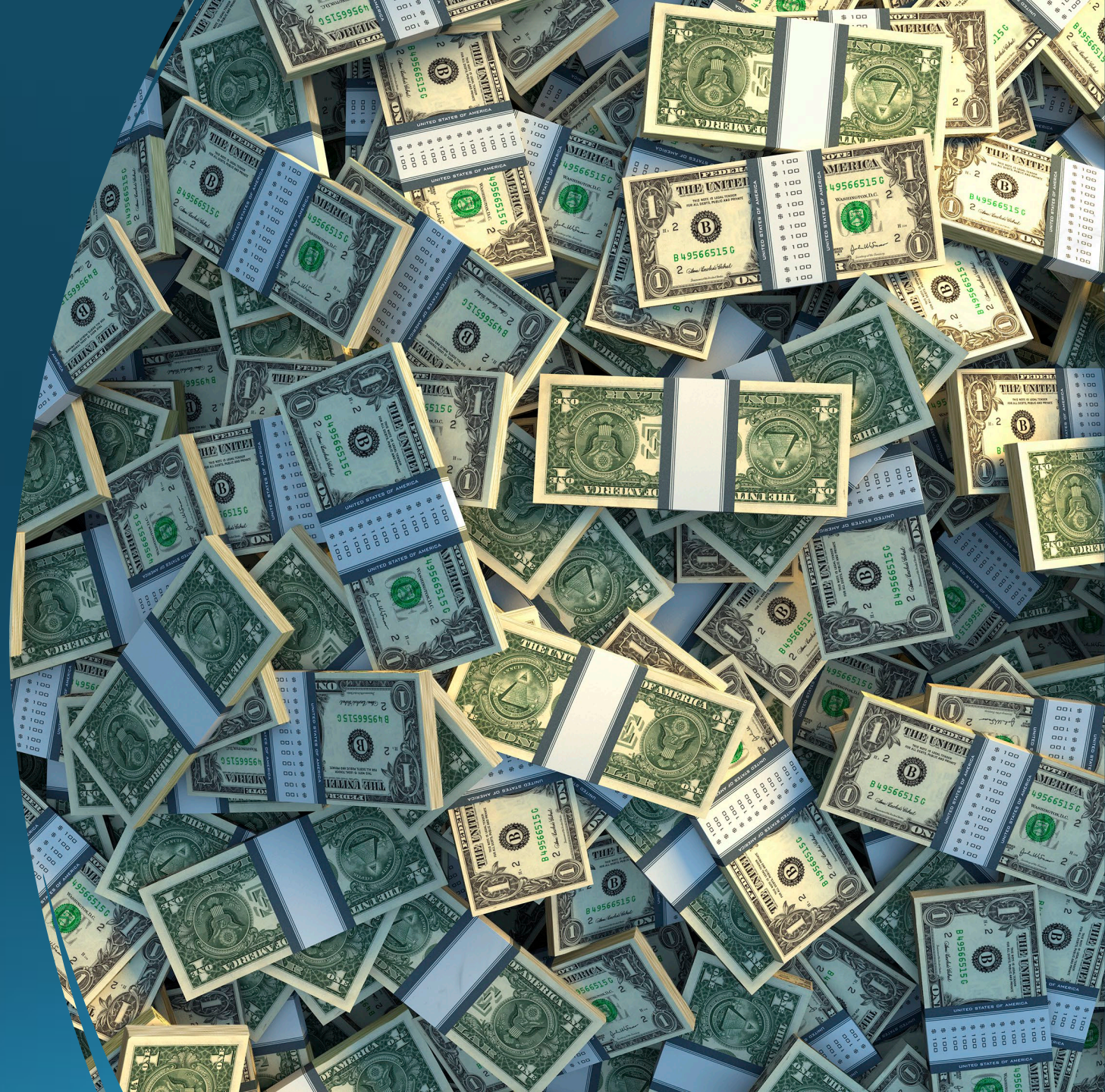
CPRB use only:

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

Verify member is not a PERS retiree.

WV RETIREMENT PLUS (457)

- Before tax and/or after tax deferred Compensation Plan
- ALL employees are eligible to participate (Temporary and Permanent)
- ALL employees must complete enrollment upon hire
- If enrollment is not completed, automatic enrollment will begin
- Deferred contributions can be changed at anytime



WEST VIRGINIA RETIREMENT plus

BUILDING A BRIDGE TO YOUR FUTURE

STATE OF WEST VIRGINIA
DEFERRED COMPENSATION PLAN
PARTICIPATION AGREEMENT

Rev. 5/3/2021

Check ✓the appropriate transaction below.

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

PARTICIPANT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____

ADDRESS: STREET _____

CITY _____ STATE _____ ZIP _____

AGENCY / POLITICAL SUBDIVISION _____

PHONE: HOME _____ CELL _____ WORK _____

EMAIL _____

_____ *Date of Birth*

_____ *Social Security #*

_____ *Date of Employment*

Former Plan Participant? Check if yes ☐

_____ *Agency / Political Subdivision Work Location*

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

WEST VIRGINIA RETIREMENT plus
BUILDING A BRIDGE TO YOUR FUTURE

Beneficiary Designation
Governmental 457(b) Plan

State of West Virginia Retirement Plus Deferred Compensation Plan **98947-01**

For My Information

- *For questions regarding this form, visit the website at www.wv457.com or contact Service Provider at 1-800-551-4218.*
- *Use black or blue ink when completing this form.*

A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

Social Security Number *(Must provide all 9 digits)* ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Last Name First Name M.I.
(The name provided MUST match the name on file with Service Provider.)

Date of Birth / /

Daytime Phone Number ( )

Email Address

Alternate Phone Number ( )

❑ Married ❑ Unmarried

B Beneficiary Designation *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation *(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

%
% of Account Balance Primary Beneficiary Name
(Name of Individual, Trust, Charity, etc.)
( )
Phone Number *(Optional)*
Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

%
% of Account Balance Primary Beneficiary Name
(Name of Individual, Trust, Charity, etc.)
( )
Phone Number *(Optional)*
Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

%
% of Account Balance Primary Beneficiary Name
(Name of Individual, Trust, Charity, etc.)
( )
Phone Number *(Optional)*
Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

Contingent Beneficiary Designation *(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

%
% of Account Balance Contingent Beneficiary Name
(Name of Individual, Trust, Charity, etc.)
( )
Phone Number *(Optional)*
Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

%
% of Account Balance Contingent Beneficiary Name
(Name of Individual, Trust, Charity, etc.)
( )
Phone Number *(Optional)*
Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

Last Name | First Name | M.I. | Social Security Number | 98947-01 Number

B **Beneficiary Designation** *(Attach an additional sheet to name additional beneficiaries.)*

Contingent Beneficiary Designation *(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

_____ %

% of Account Balance

Contingent Beneficiary Name
(Name of Individual, Trust, Charity, etc.)

(____) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

C **Participant Consent for Beneficiary Designation** *(Please sign on the 'Participant Signature' line below.)*

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. I acknowledge and agree that it is my responsibility to monitor the beneficiary designations in my account and to update the beneficiary designations as I deem necessary upon a change in marital status, death of a beneficiary or any other change that may impact my beneficiary designations.

If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Service Provider. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100%. The percentages can be divided up to two decimal points (Example: 33.33%).**

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature _____ **Date** ***(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

D **Delivery Instructions**

After all signatures have been obtained, this form can be

Uploaded Electronically:
Login to account at
www.wv457.com
Click on Upload Documents to submit

OR

Sent Regular Mail to:
Empower Retirement
PO Box 173764
Denver, CO 80217-3764

OR

Sent Express Mail to:
Empower Retirement
8515 E. Orchard Road
Greenwood Village, CO 80111

We will not accept hand delivered forms at Express Mail addresses.

PEIA CERTIFICATES/BROCHURES

- Group term life certificate of Insurance (10,000 Basic Life)
- PEIA Group term life and AD& D Insurance and rates
- PEIA Shopper's Guide

PEIA ENROLLMENT FORMS

- ***BASIC LIFE ENROLLMENT FORM***
- ***HEALTH BENEFITS ENROLLMENT FORM***
- ***OPTIONAL LIFE AND DEPENDENT LIFE ENROLLMENT FORMS***

- All forms must be completed and returned
- All birthdates, SS#, addresses, dates and signatures MUST be completed in full
- All dependents MUST include documentation (birth and/or marriage certificates)
- DAS will complete the Agency Section before submitting to PEIA
- Tobacco Affidavit MUST be completed

securian FINANCIAL™

West Virginia Public Employees
Insurance Agency

Group term life certificate of insurance

Your life insurance products are issued by Minnesota Life Insurance Company, an affiliate of Securian Financial.

Effective July 1, 2013 as revised on May 7, 2021

191979 10-2018 DOFU 11-2018
632015

securian FINANCIAL®

PEIA
Group term life and accidental death and dismemberment insurance (AD&D)
Active employees
Plan year July 1, 2021, to June 30, 2022

Insurance products issued by: Minnesota Life Insurance Company

Guaranteed coverage – get quick coverage with no medical exam or health questions

Every moment counts – no matter where you are in life, there are many reasons to consider life insurance. As your life, career and/or family changes, consider the following coverage options without answering health questions, also known as evidence of insurability (EOI).

During the calendar month in which you are hired and the two calendar months immediately following your date of hire, you may elect the following coverage options without answering health questions:

- Employee – Basic life and optional life guaranteed up to $100,000
- Dependents – Dependent life insurance Plans 1-4 are guaranteed; Plan 5 requires health questions

Elections made outside of initial eligibility and elections exceeding these amounts require EOI.

NEW THIS YEAR

How do I learn more?

Utilize our online benefits decision tool, Benefit Scout®, to help you and your family make your life insurance elections with confidence.

Visit LifeBenefits.com/PEIA to get started.

BASIC LIFE

State of West Virginia Public Employee Insurance Agency

Basic Life Enrollment Form

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

Employee

Legal Name (Last)	(First)	(M I)	(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)

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

Beneficiary(ies)

Please delegate the beneficiary(ies) of this basic term life insurance policy in the space provided below. The name of the beneficiary should be fully spelled out and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. K. Doe". If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries that survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Beneficiary Legal Name (Last, First, MI, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%

Coverage

Decreasing Term Benefit For Active Employees for:

Employee under age 65	$10,000
Employee Age 65 but under 70	$6,500
Employee Age 70 and over	$5,000

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 use tobacco, you will receive the discount on your health and Opt/Dep 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

Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? ☐ Yes ☐ No

Acceptance

☐ I hereby accept the Basic 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.

☐ I do not wish to participate in PEIA Basic Life Insurance. I decline to participate in Basic Life Insurance.

Employee's Signature: Date:

Agency

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

May 2017

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"

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)

Dependent Information

If you need additional 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 Number	Other Health Insurance (Plan Name)

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 bedside 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

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

Acceptance

☐ 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:

September 2019

OPT/DEP

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

Do you participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA if available? ☐ Yes ☐ No

Optional Life

**An asterisk beside the plan number means Guaranteed Issue for New Hires within their initial enrollment period.

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.

Employee's Age	☐ Plan 1**	☐ Plan 2**	☐ Plan 3**	☐ Plan 4**	☐ Plan 5**	☐ Plan 6**	☐ Plan 7**	☐ Plan 8**	☐ 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	☐ Plan 10**	☐ Plan 11	☐ Plan 12	☐ Plan 13	☐ Plan 14	☐ Plan 15	☐ Plan 16	☐ Plan 17	☐ 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	67,5000	90,000	112,500	135,000	157,500	180,000	202,500	225,000

The name of the beneficiary should be fully spelled out and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. K. Doe". If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries that survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Beneficiary Legal Name (Last, First, MI, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%

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.

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4	☐ Plan 5
$5,000 for your spouse $2,000 for each child	$10,000 for your spouse $4,000 for each child	$15,000 for your spouse $7,500 for each child	$20,000 for your spouse $10,000 for each child	$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: ☐ **Policyholder** ☐ **Dependent (spouse and/or children)**

☐ **No Tobacco Users within the last (6) months**

Acceptan

☐ **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.

☐ **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:

Revised April 2019

State of West Virginia Public Employee Insurance Agency

Change In Status Form

Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

CIS

Employee

Full 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)

Change

Please indicate the status change you are making:

☐ **Name Change:** ☐ **Policyholder** ☐ **Dependent (Last)**_____ **(First)**_____ **(MI)**____

☐ **Add Dependents to:** ☐ **Health** **Dependent/Optional Life** ☐ **Plan 1** ☐ **Plan 2** ☐ **Plan 3** ☐ **Plan 4** ☐ **Plan 5**

Complete Dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.

☐ **Remove Dependents from:** ☐ **Health** **Dependent Optional Life:** ☐ **Plan 1** ☐ **Plan 2** ☐ **Plan 3** ☐ **Plan 4** ☐ **Plan 5**

☐ **Change in Health Coverage from Plan**_____ **to Plan**_____

☐ **Add Health Coverage** ☐ **PEIA Plan A** ☐ **PEIA Plan B** ☐ **PEIA Plan C** ☐ **PEIA Plan D**
☐ **The Health Plan HMO Plan A** ☐ **The Health Plan HMO Plan B** ☐ **The Health Plan PPO Plan C**

☐ **Drop Health Coverage. Keep Life Insurance Only.** This terminates Health Coverage for Policyholder and all dependents.

☐ **Tobacco Status Change**

☐ **Other,** Please Specify_____

For each Qualifying event PEIA requires documentation. To add a dependent, PEIA requires documentation to substantiate legal dependency. Please see your Benefit Coordinator for questions about necessary documentation. The member's name, social security number and agency of employment must be written across the top of all documents submitted to PEIA.

NOTE: If you have Mountaineer Flexible Benefits, you must update that plan separately by completing an FBMC enrollment form. Please visit **https://peia.wv.gov/Forms-Downloads/Pages/Mountaineer-Flexible-Benefits.aspx** for more information.

Dependent Information

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 Number	Other Health Insurance (Plan Name)

State of West Virginia Public Employee Insurance Agency
Change In Status Form

Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

CIS

Change in Status Reason

☐ Marriage	☐ Death of a dependent	☐ Open Enrollment
☐ Divorce	☐ Birth of a Child	☐ Affordable Care Act
☐ Unpaid Leave of Absence by Employee, Spouse or Dependent	☐ Significant Change in Health Coverage	☐ Change from full-time to part-time or vice versa of the employee, spouse or dependent
☐ Adoption	☐ Beginning or end of a dependent's employment	☐ Other (Please Specify):

COBRA

Under federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by HealthSmart Solutions, who administers COBRA for PEIA. You will have a limited amount of time to elcect continuation of coverage.
COBRA premiums include both the employer and employee share of the premium, as well as an adminstrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact HealthSmart at 1-888-440-7342.
If the dependent's address is different than the policyholder's address, please provide the dependent's mailing address below:
Dependent Name: _____
Street Name: _____
City, State and Zip: _____

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 use tobacco, you will receive the discount on your health and Opt/Dep 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

Acceptance

☐ 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 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.

Employee's Signature: **Date:**

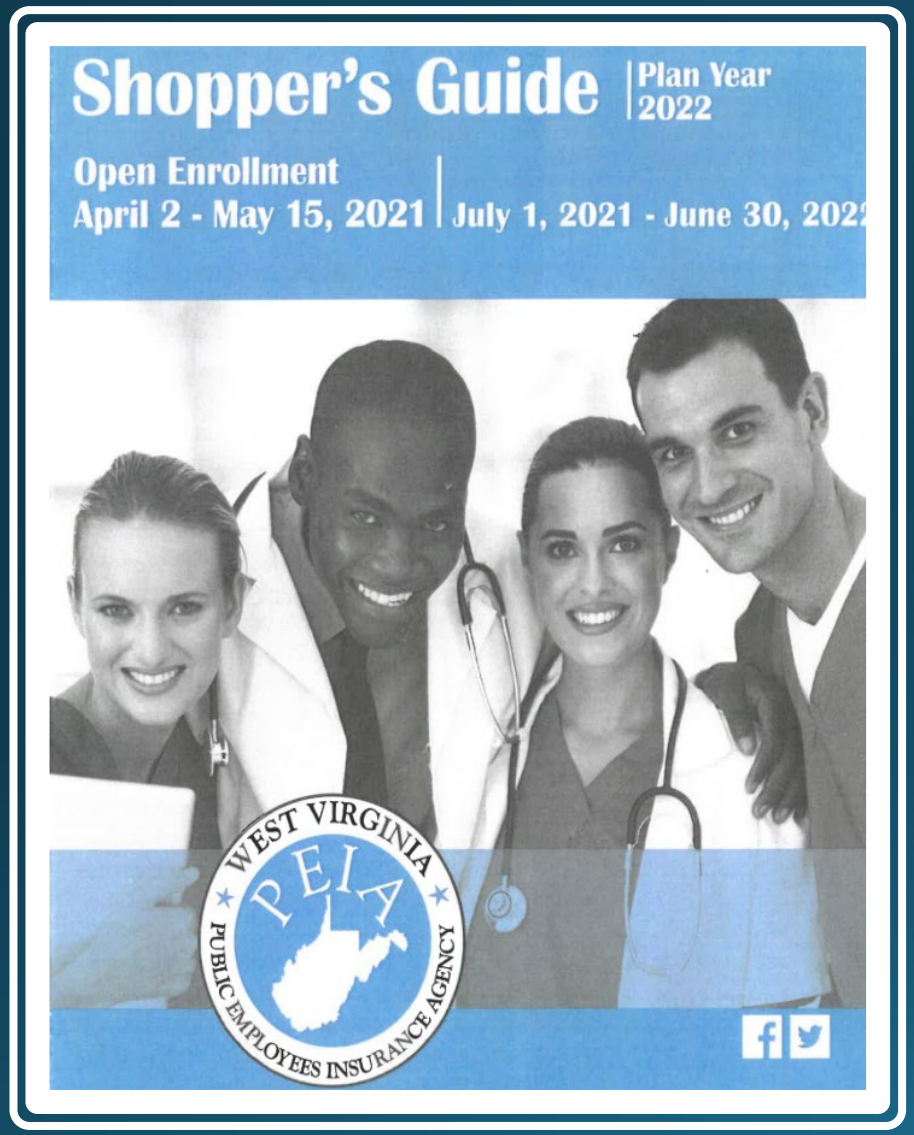
Agency

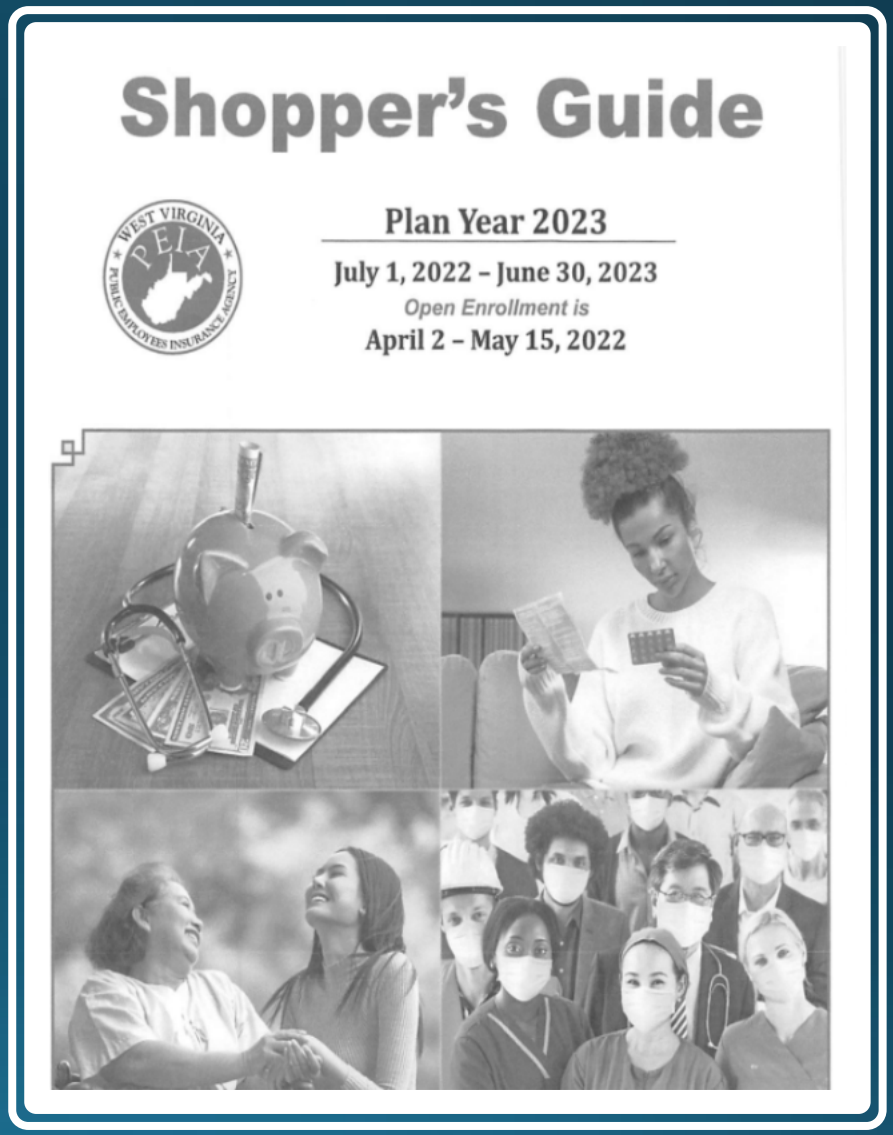
Agency Name	Account Number
Effective Date of Status Change	Index Code

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:

July 2021


Shopper's Guide
Plan Year 2022
Open Enrollment
April 2 - May 15, 2021
July 1, 2021 - June 30, 2022
WEST VIRGINIA
PEIA
PUBLIC EMPLOYEES INSURANCE AGENCY


Shopper's Guide
WEST VIRGINIA
PEIA
PUBLIC EMPLOYEES INSURANCE AGENCY
Plan Year 2023
July 1, 2022 – June 30, 2023
Open Enrollment is
April 2 – May 15, 2022

SHOPPER'S GUIDE QUICK REFERENCE

HEALTH COVERAGE:

- Benefit at-a-glance: Pages 12-29
- Tobacco-Free Premium Discount: Page 31
- Monthly Premium (Employee ONLY): Page 32
- Monthly Premium (Employee and Child(ren): Page 33
- Monthly Premium (Family): Page 34
- Family with Employee Spouse: Page 35

OPTIONAL LIFE:

- Active Employees Optional Life and AD &D Insurance: Pages 48-49
- Active Employees Optional Dependent Life and AD & D Insurance: Page 46

SUMMARY PLAN DESCRIPTION BOOK:

- PEIA Optional Plans and Eligibility for Active Employees: Pages 10-18
- Definition of Qualifying Event and Documentation required: Page 30-31
- Prescription Drug Benefits: Pages 91-110
- **DIVORCE:** If a divorce occurs, the ex-spouse and/or any dependent stepchild(ren), MUST be removed immediately form your ALL PEIA AND MT FLEX insurance plans. If the court requires you to continue coverage per the divorce decree, you must find coverage through COBRA or from another insurer other than PEIA. ***See page 33 – Voluntary Termination of Benefits.***

MOUNTAINEER FLEX (FBMC):

- Benefits at-a-glance: Pages 11-12

QUESTIONS? See important contact numbers on Pages 2-3

SUMMARY PLAN DESCRIPTIONS (SPD) PLANS A, B & D & PPB PLAN C

- SPD disclosure all information about the adjacent health plan
- Federal Exemptions to coverage
- Summary of Benefits and Coverages under designated plans
- Terms & Definitions
- Prescription drug benefits/drugs and/or services NOT covered
- Filing claims/appealing a claim
- Pharmacy information
- Premiums conversions
- COBRA

Summary Plan Description
Plans A, B & D

Plan Year 2022

July 1, 2021 – June 30, 2022

Summary Plan Description
PPB Plan C

Plan Year 2022

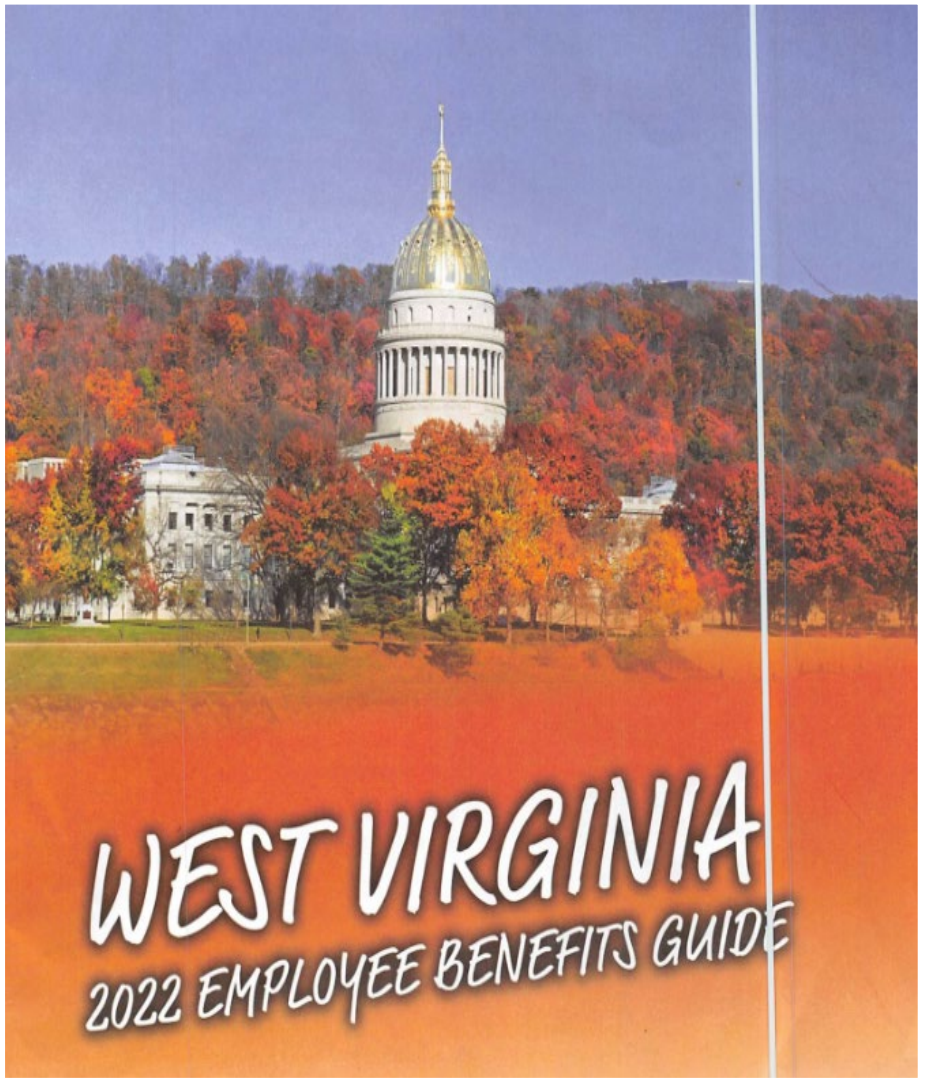
July 1, 2021 – June 30, 2022

FBMC®

BENEFITS MANAGEMENT

EMPLOYEE PAID BENEFITS INCLUDING:

*Dental
*Vision
*Hearing
*Short-Term Disability
*Long-Term Disability
*Legal
*Health and Dependent
*Flexible Spending Account
*Health Savings Account


WEST VIRGINIA
2022 EMPLOYEE BENEFITS GUIDE


WEST VIRGINIA
PEIA
PUBLIC EMPLOYEE INSURANCE AGENCY
MOUNTAINEER
FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.
WEST VIRGINIA
2023 EMPLOYEE FLEXIBLE BENEFITS GUIDE

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

STATE OF WEST VIRGINIA EMPLOYEE ENROLLMENT FORM

July 1, 2022 - June 30, 2023

MOUNTAINEER FLEXIBLE BENEFITS

1.

INSTRUCTIONS: DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2022

WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?
- 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.**

HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:
- **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 family coverage for any benefit, you must provide dependent information in Section 4.

CHANGE IN ELECTION
- 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.

GEN#	E-MAIL	☐ 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 / OFFICE PHONE

3.

MOUNTAINEER FLEXIBLE BENEFITS (PAID BY EMPLOYEES)

Keep Coverage	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS (If you select DEPENDENT coverage for dental, vision or hearing, you must complete the dependent information in SECTION 4.)		COST PER PAY PERIOD
☐	☐	☐	☐	DENTAL (Choose One Option) ☐ Routine ☐ Assistance ☐ Basic ☐ Enhanced	☐ 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	
☐	☐	☐	☐	LONG-TERM DISABILITY INCOME PLAN Employee Only ☐ 60% Coverage Level ☐ 70% Coverage Level		
☐	☐	☐	☐	SHORT-TERM DISABILITY INCOME PLAN Employee Only		
☐	☐	☐	☐	HEALTH CARE FLEXIBLE SPENDING ACCOUNT All Claims Must Be Submitted By October 31, 2023		
☐	☐	☐	☐	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT All Claims Must Be Submitted By October 31, 2023 ☐ Married, Filing Separately ☐ Married, Filing Jointly ☐ Single, Head Of Household		
FOLD LINE						
☐	☐	☐	☐	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 ($3,650 maximum for PY 2022) ☐ Family ($7,300 maximum for PY 2023) ☐ Over 55 Catch-up (additional maximum $1,000)	
☐	☐	☐	☐	LIMITED HEALTH CARE FSA Must be enrolled in HSA.		
☐	☐		☐	LEGAL (POST-TAX) ☐ Ultimate Advisor® Employee & Family	☐ Ultimate Advisor Plus™ Employee & Family	
				TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD		

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
	Spouse							

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. 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 INMTICIRITION 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, 2022.

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 23, 2022.**

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED

STATE CREDIT UNION

- All employees eligible to join
- Non-profit/employee owned financial organization
- Federally insured up to $250K / NCUA
- Payroll deduction available
- Auto, mortgage, ATV, Boat, Line-of credit, Christmas Club, Visa Credit Card
- Array of savings plans
- ATM network/ Debit Cards, Mobile Banking

STATE CREDIT UNION

SMART529®

West Virginia's Education Savings Solution

Qualified tuition plan defined by Section 529 of IRS code

Flexible and easy way to save for educational needs

Federal and WV tax benefits

NO minimum initial investment and no minimum subsequent investments

Payroll Direct Deposit and Automatic payments available

SELF – PAY

PEIA

&

MT. FLEX

Self Paying Insurance Premiums

You will run into this when you have an employee that is off payroll for medical leave, personal leave, or any other type of leave.

- The first thing you will need to do is get the premium amount's for PEIA and MTFLX that is owed to keep the insurance current each month. This will need to be filled out on the Self pay acknowledgement form that the employee will need to sign to acknowledge they are liable to send in a payment by the 5th of each month.

- The acknowledgement form is important so we can show the employee is aware that they are responsible for paying their part of their insurance coverage. We need to have at least one on file. On the same form they can also chose to terminate their insurance. If they chose to terminate, they will just keep the basic life coverage.

- Please keep a spreadsheet that tracks what payments have been made, what months or checks they cover and what ones are still due. It is vital in keeping track of where the employees are with their payments. If you need any assistance with making a spreadsheet, please see Sharon Dunbar.

- Payments will need to be via check or money order. PEIA and MTFLX payment will need to be on separate checks. For PEIA payments please make sure the check is made out to DAS. MTFLX payments can be made out to MTFLX. The FBMC personal pay Summary will need to be completed with the check. Do not mail check's to MTFLX directly or we cannot keep track of the payment.

- Once you have the acknowledgement forms and checks ready to go you will need to make a copy to retain for you own files and send to DASHR, so we know the check is on the way. Emails letting us know what checks are coming are very important so we can monitor when we receive them and will know if one is missing. Please send all checks to: **Division of Administrative Services**

  1124 Smith St. Suite 2100

  Charleston, WV 25301

  ATTN: Summer Stepp

- Employee's who do not maintain their premiums will be terminated after 2 months of non-payments. Employees have the right to appeal the termination but if approved by PEIA the total amount of all past payments will be due to reinstate the insurance. In the event an employee is terminated twice within a 12-month period PEIA reserves the right to deny reinstation of coverage.

Self-Pay: PEIA and/or Mt. Flex

Employees that are going off payroll must sign below.
Your coverage as an active policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due. Premiums are due by the fifth day of the month following the month for Example: May premium is due by June 5th. If payment is not received when due coverage will be cancelled, and all claims incurred will be your personal responsibility.
Read PEIA Summary Plan Description Book pages 30 & 31.

I _____ hereby acknowledge that to maintain my insurance I must pay by the 5th of each month.
Facility_____.

PEIA insurance $_____total per month and if missing ½ month premium $_____ (make check out to DAS).

Mt. Flex insurance $_____total per month and if missing ½ month premium$_____ (make check out to FBMC or Mt. Flex).

To Term:
PEIA: Employees can fill out a Change-In-Status form and mark (Drop Health Coverage. Keep Basic Life Insurance Only and on the 2nd page mark Change in Status Reason, sign and date the form.
FBMC-Mt. Flex: Employee can fill out a FBMC form and mark (CIS) and Cancel Coverage or the Benefit Coordinator can write across the top of the form cancel benefits and state why the employee is going off payroll and email to Mt. Flex.
To reinstate:
When you return to work you must pay back all missing premiums or wait until the next Open Enrollment to sign up. (excluding Military Leave and Long-Term Workers' Comp.).

To TERM: I_____
would like to **term** my Mt. Flex and PEIA (Keep Basic Life).

Employee's Signature: _____**Date:** _____

SD-11/20/2020

FBMC
Benefits Management

STATE OF WEST VIRGINIA

Active Employees Personal Pay Summary Form

Agency: _____

Employee Name: _____

Last Four Digits of Ss# _____ FBMC 4-Digit Work Location _____

Check # _____ Check Dollar Amount _____

INSTRUCTIONS: Please return this completed document and payment to your local Benefits Coordinator for distribution to FBMC. Please note: payments will NOT be accepted unless accompanied by this completed document. Benefit Coordinator signature is required.

Benefit Coordinator: _____ Date: _____

Benefit Coordinator Signature: _____

MAKE CHECKS PAYABLE TO:
WV – Mountaineer Flexible Benefits

MAIL THIS FORM WITH YOUR CHECK TO:

Division of Administrative Services
1124 Smith Street-Suite 2100
Charleston, WV 25301
ATTN: Summer Stepp

SELF-PAYMENT TRACKING LOG

* EMPLOYEE'S NAME
* MONTHLY PREMIUM
* PREMIUM PAID (FULL MONTH OR 1/2 MONTH AND THE AMOUNT)
* PREMIUM COVERED FOR WHICH PAY PERIOD
* CHECK NUMBER OR MONEY ORDER NUMBER
* DATE OF CHECK OR MONEY ORDER

DIVORCE

Qualifying event such as DIVORCE must be reported immediately.

Even if you do not have any paperwork report this immediately to:

PEIA: Sharon Withrow Sharon.K.Withrow@wv.gov

Sharon.R.Dunbar@wv.gov and your Benefit Coordinator at DAS.

PEIA will flag their system so claims will not be paid on the ex-spouse and stepchildren after the end of the month of the divorce.

Give employee forms to make the changes:

PEIA- Change-In-Status form

PEIA- Basic and/or Optional Life Insurance Change of Beneficiary Form

PERS- Pre-Retirement Beneficiary Designation Form

Mt. Flex form and mark Change-In-Status

PEIA COVERAGE DUE TO DIVORCE

STATE OF WEST VIRGINIA
DEPARTMENT OF MILITARY AFFAIRS & PUBLIC SAFETY
DIVISION OF CORRECTIONS AND REHABILITATION

JEFF S. SANDY, CAMS, CFE	BETSY C. JIVIDEN	DONALD AMES
CABINET SECRETARY	COMMISSIONER	SUPERINTENDENT

TO:

FROM:

DATE: 29 August 2019

RE: Divorce final February 2019

[illegible] you should have termed your spouse once divorce was final on February 22nd 2019, this would have been effective March 1st 2019, you failed to report this Change In Status until August 29th 2019. Therefore, PEIA has to collect the difference, you were carried under Employee and Family, once you reported the divorce in the time limit allowed it would have been changed to Employee and Children.

I have broken it down to show you the difference:

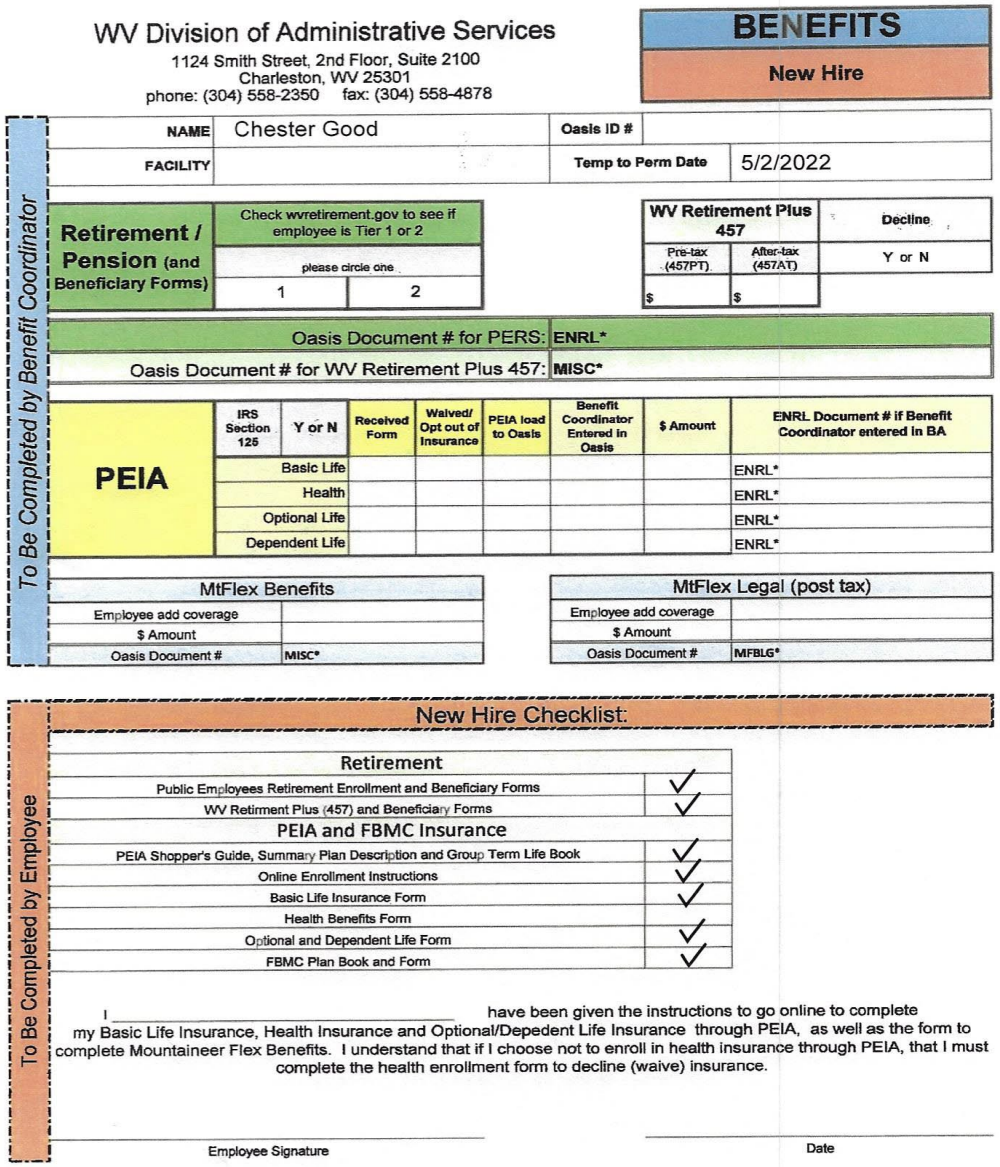
	Employer paid For Family	Employer should have paid for Employee Children
Mar. 2019	$788.00	$411.00
Apr. 2019	$788.00	$411.00
May 2019	$788.00	$411.00
June 2019	$788.00	$411.00
July 2019	$803.00	$426.00
Aug. 2019	$803.00	$426.00
	$4758.00	$2496.00

Difference being $2262.00 owed to Employer

I [illegible] agrees to pay the total of $2262.00 for the PEIA outstanding Employer's premiums due to not reporting my divorce in a timely manner.

Name Date

Tlt: file



WV Division of Administrative Services
1124 Smith Street, 2nd Floor, Suite 2100
Charleston, WV 25301
phone: (304) 558-2350 fax: (304) 558-4878

BENEFITS
New Hire

To Be Completed by Benefit Coordinator

NAME	Chester Good	Oasis ID #	
FACILITY		Temp to Perm Date	5/2/2022

Retirement / Pension (and Beneficiary Forms)	Check wvretirement.gov to see if employee is Tier 1 or 2	
	please circle one	
	1	2

WV Retirement Plus 457		Decline
Pre-tax (457PT)	After-tax (457AT)	Y or N
$	$	

Oasis Document # for PERS:	ENRL*
Oasis Document # for WV Retirement Plus 457:	MISC*

PEIA	IRS Section 125	Y or N	Received Form	Waived/ Opt out of Insurance	PEIA load to Oasis	Benefit Coordinator Entered in Oasis	$ Amount	ENRL Document # if Benefit Coordinator entered in BA
	Basic Life							ENRL*
	Health							ENRL*
	Optional Life							ENRL*
	Dependent Life							ENRL*

MtFlex Benefits	
Employee add coverage	
$ Amount	
Oasis Document #	MISC*

MtFlex Legal (post tax)	
Employee add coverage	
$ Amount	
Oasis Document #	MFBLG*

To Be Completed by Employee

New Hire Checklist:

Retirement	
Public Employees Retirement Enrollment and Beneficiary Forms	✓
WV Retirment Plus (457) and Beneficiary Forms	✓
PEIA and FBMC Insurance	
PEIA Shopper's Guide, Summary Plan Description and Group Term Life Book	✓
Online Enrollment Instructions	✓
Basic Life Insurance Form	✓
Health Benefits Form	
Optional and Dependent Life Form	✓
FBMC Plan Book and Form	✓

I _____ have been given the instructions to go online to complete my Basic Life Insurance, Health Insurance and Optional/Depedent Life Insurance through PEIA, as well as the form to complete Mountaineer Flex Benefits. I understand that if I choose not to enroll in health insurance through PEIA, that I must complete the health enrollment form to decline (waive) insurance.

_____ Employee Signature

_____ Date

SCENARIO 1

PLEASE TELL US WHAT **THREE** THINGS ARE MISSING ON THIS FORM?

ANSWER

- **BENEFITS—New Hire form--Chester Good:**

(1) Facility Name is missing

(2) The employee didn't write his name on the line: I _____ have been given the instructions to go online to complete .....

(3) Missing Policyholder's Signature and Date

SCENARIO 2

PLEASE TELL US WHAT **THREE** THINGS ARE MISSING ON THIS FORM?

Consolidated Public Retirement Board
4101 MacCorkle Avenue, SE
Charleston, WV 25304
304-558-3570 or 800-654-4406
www.wvretirement.com

Public Employees Retirement System (PERS) Enrollment Form

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: Please complete Sections 1 and 2 and return this form to CPRB.

Full Name	SSN	Date of Birth	Telephone Number
Festus Hagen		7-2-1916	

Gender	Member Mailing Address	City	State	Zip Code
☐ Female ☐ Male	Main Street-Jail House	Dodge City	KS	67801

Employer Name	Date of Hire with Current Employer	Job Position
Dodge City Correctional Central	5-2-2022	Deputy Sheriff

Position Status	Scheduled Hours Per Day	Payroll Frequency
☑ Full Time ☐ Elected ☐ Part Time ☐ Temporary	24/7	☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☑ Monthly

Type of Rate of Pay	Rate of Pay	Employment Payment Type
☐ Daily ☐ Hourly ☐ Monthly ☑ Yearly	$ 120,000.00	☐ Hourly ☑ Salaried ☐ Per Diem/Daily

Are you currently retired under any of the State's Retirement Systems? ☐ No ☑ Yes
If Yes, please provide the employer:

Have you previously contributed to the Public Employees Retirement System? * ☑ No ☐ Yes

Name of Spouse	Spouse Date of Birth	Spouse SSN
April Hagen	7-2-1918	202-02-2022

Section 2: Voluntary Election to Participate: Please See Eligibility Criteria Below

IF YOU ARE AN ELECTED OFFICIAL OR A RETIRED MEMBER OF THE WV STATE POLICE DEATH, DISABILITY AND RETIREMENT SYSTEM (PLAN A), WV STATE POLICE RETIREMENT SYSTEM (PLAN B), WV DEPUTY SHERIFF RETIREMENT SYSTEM (DSRS), OR ANY MUNICIPAL POLICE OR FIREFIGHTER RETIREMENT SYSTEM, YOU HAVE THE OPTION TO ELECT *NOT* TO PARTICIPATE IN PERS.

Please select the box below if you fall under one of the above criteria and you *VOLUNTARILY ELECT* to participate in PERS.

NOTE: YOUR DECISION TO PARTICIPATE IN PERS IS IRREVOCABLE ONCE CPRB RECEIVES YOUR FIRST CONTRIBUTION.

☐ **I wish to participate in PERS**

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.			
3.			

**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.*

Signature _____ Date _____

Section 3: Internal CPRB 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)

CPRB Staff Name: _____ Date: _____

Updated July 2016

ANSWER

- **Public Employees Retirement System (PERS) Enrollment Form: Festus Hagen:**

- 1st page

(1) Missing Social Security Number

(2) Didn't mark Gender (Female or Male)

(3) Missing Policyholder's Signature and 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
April Hagen Primary ☑ Secondary ☐	202-02-2022	7-2-1918	Wife	50 %
Kitty Russell Primary ☑ Secondary ☐		7-2-1917	Friend	50 %
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. Please call the CPRB when this time occurs. 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: Festus Hagen	SSN:	Date of Birth: 7-2-1916
Mailing Address: Main Street-Jail House		
City: Dodge City	State: KS	Zip Code: 12878
Employer: Dodge City CC	Work Phone:	Home Phone:
Member Signature: X		Date: 5-2-2022
Witness Printed Name (Cannot be a named beneficiary): Mark Beckner	Witness Signature: Mark Beckner	Date: 5-31-2022
Witness Mailing Address: 1124 Smith Street, Charleston WV 25301		Witness Telephone: 304-558-2350

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.

SCENARIO 3

PLEASE TELL US WHAT **THREE** THINGS ARE MISSING ON THIS FORM?

ANSWER

- 2nd page—Beneficiary page

(1) Missing Social Security Number for Kitty

(2) Missing Social Security Number for Festus

(3) Both Signature dates must be the same

SCENARIO 4

PLEASE TELL US WHAT **THREE** THINGS ARE MISSING ON THIS FORM?

WEST VIRGINIA RETIREMENT plus
BUILDING A BRIDGE TO YOUR FUTURE

STATE OF WEST VIRGINIA DEFERRED COMPENSATION PLAN PARTICIPATION AGREEMENT

Rev. 5/3/2021

Check ✓the appropriate transaction below.

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

PARTICIPANT INFORMATION

NAME: LAST Pheeters FIRST Louie MIDDLE _____

1-1-1916
Date of Birth

ADDRESS: STREET Horse Stable

_____
Social Security #

CITY Dodge City STATE KS ZIP 67801

5-2-2022
Date of Employment

AGENCY / POLITICAL SUBDIVISION _____

PHONE: HOME _____ CELL _____ WORK _____

Former Plan Participant? Check if yes ☐

EMAIL _____

_____
Agency / Political Subdivision Work Location

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**

Mark Beckner 5-2-2022
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

ANSWER

WV Retirement Plus—Louie Pheeters

(1) Didn't mark the top (Appropriate Transaction)

(2) Missing Social Security Number

(3) Missing Policyholder's Signature and Date

BASIC LIFE

State of West Virginia Public Employee Insurance Agency
Basic Life Enrollment Form
Complete this form to enroll for Basic Life Insurance. Complete all sections of the form except "AGENCY"

Employee

Legal Name (Last)	(First)	(M I)	(Generation: Jr., Sr., etc.)	Social Security Number
Dillon	Matt	J		019-14-1919
Mailing Address	County of Residence			Home Telephone
Main Street-Jail House				( )
City	State	Zip		Work Telephone
Dodge City	KS	67801		( )
Physical Address				Sex (Circle one) M F
City	State	Zip		Date of Birth (mm/dd/yy)

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

Beneficiary(ies)

Please delegate the beneficiary(ies) of this basic term life insurance policy in the space provided below. The name of the beneficiary should be fully spelled out and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. K. Doe". If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries that survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Beneficiary Legal Name (Last, First, MI, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%

Coverage

Decreasing Term Benefit For Active Employees for:

Employee under age 65	$10,000
Employee Age 65 but under 70	$6,500
Employee Age 70 and over	$5,000

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 use tobacco, you will receive the discount on your health and Opt/Dep 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

Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? ☐ Yes ☐ No

Acceptance

☑ I hereby accept the Basic 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.

☐ I do not wish to participate in PEIA Basic Life Insurance. I decline to participate in Basic Life Insurance.

Employee's Signature: Date:

Agency

Agency Name	Account Number	Date of Employment
Dodge City CC	7-2022-02-02	5-2-2022

Hours worked Weekly	Effective Date of Coverage	Coverage Code	Index Code
24/7	6-1-2022		10

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 : *Mark Beckner* Date: 5-2-2022

May 2017

SCENARIO 5

PLEASE TELL US WHAT **FIVE** THINGS ARE MISSING ON THIS FORM?

ANSWER

- **PEIA Basic Life-Enrollment Form—Matt Dillon:**

(1) Didn't mark Gender (Female or Male)

(2) Date of Birth is Missing (DOB)

(3) Didn't fill in Tobacco Affidavit

(4) Didn't complete the IRS 125 Premium Conversion Plan

(5) Missing Policy Holder's Signature and Date

SCENARIO 6

PLEASE TELL US WHAT **FOUR** THINGS ARE MISSING ON THIS FORM?

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"

Employee

Legal Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Dillon	Matt			202-16-1616
Mailing Address		County of Residence		Home Telephone
111 Main Street				( )
City	State	Zip		Work Telephone
Dodge City	KS	67801		( )
Physical Address				Sex (Circle one) M F
Jail House				
City	State	Zip		Date of Birth (mm/dd/yy)
				2-14-1916

Dependent Information

If you need additional 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 Number	Other Health Insurance (Plan Name)

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 bedside 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

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

Acceptance

☐ 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: Matt Dillon Date: 5/2/2022

Agency

Agency Name	Account Number	Date of Employment
Dodge City CC	7-2022-02-02	5-2-2022
Hours worked Weekly	**Effective Date of Coverage**	**Index Code / Coverage Code**
24/7	6-1-2022	10

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 : Mark Beckner Date: 5-2-2022

September 2019

ANSWER

PEIA Health Benefits Enrollment Form--Matt Dillon

(1) Didn't mark Gender (Female or Male)

(2) Coverage Plan is not selected

(3) Didn't fill in Tobacco Affidavit

(4) Didn't mark the Acceptance

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

STATE OF WEST VIRGINIA EMPLOYEE ENROLLMENT FORM

July 1, 2021 - June 30, 2022

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT INC.

1.

INSTRUCTIONS: DURING OPEN ENROLLMENT, RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2021

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 family 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#	E-MAIL	☐ Open Enrollment ☐ Transfer	☐ New Hire ☐ Change in Status
LAST NAME: Dillon		FIRST NAME: Matt	MI:
HOME ADDRESS [STREET]	CITY: Dodge City	STATE: KS	ZIP: 67801
HOME PHONE			
BIRTH DATE: 2-14-1916	☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE	DATE EMPLOYED: 5-2-2022	EFFECTIVE DATE: 6-1-2022
OFFICE PHONE			

3.

MOUNTAINEER FLEXIBLE BENEFITS (PAID BY EMPLOYEES)

Keep Coverage	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS (If you select DEPENDENT coverage for dental, vision or hearing, you must complete the dependent information in SECTION 4.)		COST PER PAY PERIOD
☐	☑	☐	☐	**DENTAL** Choose One Option: ☐ Routine ☐ Assistance ☐ Basic ☐ Enhanced	☑ 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	
☐	☐	☐	☐	**LONG-TERM DISABILITY INCOME PLAN** Employee Only ☐ 50% Coverage Level ☐ 70% Coverage Level		
☐	☐	☐	☐	**SHORT-TERM DISABILITY INCOME PLAN** Employee Only		
☐	☐	☐	☐	**HEALTH CARE FLEXIBLE SPENDING ACCOUNT** All Claims Must Be Submitted By October 31, 2022.		
☐	☐	☐	☐	**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT** All Claims Must Be Submitted By October 31, 2022. ☐ 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 ($3,600 maximum for PY 2021) ☐ Family ($7,200 maximum for PY 2021) ☐ Over 55 Catch-up (additional maximum $1,000)	
☐	☐	☐	☐	**LIMITED HEALTH CARE FSA** Must be enrolled in HSA.		
☐	☐		☐	**LEGAL (POST-TAX)** ☐ Ultimate Advisor® Employee & Family ☐ Ultimate Advisor Plus™ Employee & Family		
				TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD		

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
	Spouse							

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. 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, 2021.

FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)

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

AGENCY NAME: Dodge City CC
4 DIGIT WORK LOCATION #: 0608
EFFECTIVE DATE:
NO. PAY DEDUCTIONS: 24
GROSS ANNUAL SALARY: 74,000.00
BENEFIT COORDINATOR SIGNATURE: Mark Beckner
SIGNATURE DATE: 5-2-2022
BENEFIT COORDINATOR PHONE# ( ) 444-1515
BENEFIT COORDINATOR FAX# ( ) 448-2121

ENROLLMENT FORMS SHOULD BE MAILED TO: **FBMC, PO BOX 1878,TALLAHASSEE, FL 32302-1878** DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY **MAY 21, 2021.**

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED

SCENARIO 7

PLEASE TELL US WHAT **SIX** THINGS ARE MISSING ON THIS FORM?

ANSWER

FBMC -Mt. Flex form---Matt Dillon

(1) Missing Social Security Number

(2) Missing email address

(3) Didn't mark type of Enrollment

(4) Street Address is missing

(5) Didn't select which option for dental or vision

(6) Missing Policy Holder's Signature and Date

SCENARIO 8 PAGE 1

PLEASE TELL US WHAT **THREE** THINGS ARE MISSING ON THIS FORM?

State of West Virginia Public Employee Insurance Agency
Change In Status Form

CIS

Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

Employee

Full Legal Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Dillon	Matt			202-16-1616

Mailing Address	County of Residence	Home Telephone
111 Main Street		( )

City	State	Zip	Work Telephone
Dodge City	KS	67801	( )

Physical Address			Sex (Circle one)
			M F

City	State	Zip	Date of Birth (mm/dd/yy)
Dodge City	KS	67801	2-14-1916

Change

Please indicate the status change you are making:

☐ Name Change: ☐ Policyholder ☐ Dependent (Last)_____ (First)_____ (MI)____

☐ Add Dependents to: ☑ Health Dependent/Optional Life ☐ Plan 1 ☑ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5

Complete Dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.

☐ Remove Dependents from: ☐ Health Dependent Optional Life: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5

☐ Change in Health Coverage from Plan_____ to Plan_____

☐ Add Health Coverage ☐ PEIA Plan A ☐ PEIA Plan B ☐ PEIA Plan C ☐ PEIA Plan D
☐ The Health Plan HMO Plan A ☐ The Health Plan HMO Plan B ☐ The Health Plan PPO Plan C

☐ Drop Health Coverage. Keep Life Insurance Only. This terminates Health Coverage for Policyholder and all dependents.

☐ Tobacco Status Change

☐ Other, Please Specify_____

For each Qualifying event PEIA requires documentation. To add a dependent, PEIA requires documentation to substantiate legal dependency. Please see your Benefit Coordinator for questions about necessary documentation. The member's name, social security number and agency of employment must be written across the top of all documents submitted to PEIA.

NOTE: If you have Mountaineer Flexible Benefits, you must update that plan separately by completing an FBMC enrollment form. Please visit **https://peia.wv.gov/Forms-Downloads/Pages/Mountaineer-Flexible-Benefits.aspx** for more information.

Dependent Information

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 Number	Other Health Insurance (Plan Name)
Dillon-Russell, Kitty	same	Spouse	F	2-3-1920		

July 2021

ANSWER

PEIA Change In Status Form---Matt Dillon

1st page

(1) Missing Gender (Female or Male)

(2) Box not checked to add dependent

(3) Missing Kitty's Social Security Number

State of West Virginia Public Employee Insurance Agency
Change In Status Form
Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

CIS

Change in Status Reason

☑ Marriage	☐ Death of a dependent	☐ Open Enrollment
☐ Divorce	☐ Birth of a Child	☐ Affordable Care Act
☐ Unpaid Leave of Absence by Employee, Spouse or Dependent	☐ Significant Change in Health Coverage	☐ Change from full-time to part-time or vice versa of the employee, spouse or dependent
☐ Adoption	☐ Beginning or end of a dependent's employment	☐ Other (Please Specify):

COBRA

Under federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by HealthSmart Solutions, who administers COBRA for PEIA. You will have a limited amount of time to elcect continuation of coverage.
COBRA premiums include both the employer and employee share of the premium, as well as an adminstrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact HealthSmart at 1-888-440-7342.
If the dependent's address is different than the policyholder's address, please provide the dependent's mailing address below:
Dependent Name: _____
Street Name: _____
City, State and Zip: _____

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 use tobacco, you will receive the discount on your health and Opt/Dep 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

Acceptance

☐ 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 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.
Employee's Signature: Date:

Agency

Agency Name: Dodge City CC	Account Number: 7-720-22-22
Effective Date of Status Change: 7-1-2022	Index Code: 10

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: Mark Beckner Date: 6-15-2022

July 2021

SCENARIO 8 PAGE 2

PLEASE TELL US WHAT **THREE** THINGS ARE MISSING ON THIS FORM?

ANSWER

PEIA Change In Status Form---Matt Dillon

2nd page

(1) Didn't fill out the Tobacco Affidavit

(2) Didn't mark the Acceptance

(3) Missing Policyholder's Signature and Date