# 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 DIVI	sion of		nistrat		ervices	5		BENE	FITS
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1	New Hire Checklist:	
1	Retirement	
	Public Employees Retirement Enrolment and Beneficiary Forms	
	WV Retirment Plus (457) and Beneficiary Forms	
	PEIA and FBMC Insurance	
-1	PEIA Shopper's Guide, Summary Plan Description and Group Term Life Book	
	Online Enrollment Instructions	
-1	Basic Life Insurance Form	
1	Health Benefits Form	
	Optional and Dependent Life Form	
a la start a start	FBMC Plan Book and Form	
	have been given the i my Basic Life Insurance, Health Insurance and Optional/Depedent Life Insur complete Mountaineer Flex Benefits. I understand that if I choose not to enroll complete the health enrollment form to decline (with	in health insurance through PEIA, that I mus
	Employee Signature	Date

### Pay/Holiday Calendar

#### Holidays

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

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18	19	20	21	22	23	24	16	17	18	19	20	21	22	20	21	22	23	24	25	26	18	19	20	21	22	23	24
25	26	27	28	29	30			24 31	25	26	27	28	29	27	28	29	30				25	26	27	28	29	30	31

Holidays Pay Days

WOASIS

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

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- 1		

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 Section	ions 1 and 2 and return this form to CPRB.
Full Name	SSN Dete of Birth Telephone Number
Gender Member Mailing Address	City State Zip Code
Employer Name	Date of Hire with Current Employee
Position Status  Full Time Elected Part Time Temporary	Per Day (Payol Frequency) Weekly Bi-Weekly Semi-Monthly Monthly
Type of Rate of Pay Daily Houriy Monthly Yearly \$	Employment Payment Type Hourly Salaried Per Diem/Daliy
Are you currently rotired under any of the State's Retirement Systems? No If Yes, please provide the employer:	Yes Have you previously contributed to the No Yes Public Employees Retirement System?*
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 <u>NOT</u> 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 provious 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 repold (in a lump sum or payments) within five years of the return to employment.

#### Signature

#### 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				
				%
Primery 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
lailing Address			
ity		State	Zip Code
Employer		Work Phone	Home Phone
ember Signature			Date
/itness Printed Name (Cannot be a named beneficiary) Facility Benefits Coordinator Name	Witness Signature Benefits Coordinate	x	Date
Vitness Mailing Address			Witness Telephone
Facility Address			Facility Telephone

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

Date

CPRB use only:	
Verify correct section completed based on PERS credited service and orig Verify member is not a PERS retiree.	ginal hire date.
Page 2 of	8

# 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



BUILDING A BRIDGE TO YOUR FUT		STATE OF WEST DEFERRED COMPEN PARTICIPATION A Rev. 5/3/202	SATION PLAN GREEMENT
Check -/ the appropriate transaction bel	Agency Transfer Agency Transfer Increase/Restart Salary Decrease Salary Deferral		I Name/Address Change
	PARTICI	IPANT INFORMATION	
NAME: LAST			Date of Birth
CITY	STATE	ZIP	Social Security #
AGENCY / POLITICAL SUBDIVISIO			Date of Employment
EMAIL			gency / Political Subdivision Work Location
		ERRAL ELECTION pay period of my compensation as before-I	
Effective Date: This agreement will be e	\$25 \$10	Other (write in amount) \$ ariod of my compensation after-tax as a des Other (write in amount) \$ following the completion of this form or the arral will be effective the first available payd	eignated Roth contribution to the Plan.
The State of West Virginia has establi employees. The Plan provides that eli Plan) upon executing and filing a Part Plan and an amount equal to \$10 per Plan. If you do not want to participate Benefits Coordinator within 30 days o The employee acknowledges the folio 1. I elect to participate in the Plan a 2. I agree that all rights to the defer 3. I agree that the elections indicate maximum dollar amount allowed	shed an Internal Revenue Code gible employees may elect to jo icipation Agreement with the Sti pay period will be deducted fror in the Plan at this time, please of f your date of employment. If you wing: ind agree to defer compensation red compensation shall be gove id above will remain in effect un under the Plan and Code. If the uth any Internal Revenue Code	ate. Employees hired on or after July 1, m your pay and deposited into an accour- theck the 'Decline Automatic Enrollment ou elect this option, you may choose to e in to the Plan in accordance with the Plan- med by the terms and conditions of the	n Plan (Plan) for the benefit of its subject to the limitations established in the 2007 will be automatically enrolled into the 2007 will be automatically enrolled under the t' option above and return the form to your enroll in the Plan at a later date. and Internal Revenue Code (Code). Plan and Code. y contributions during any year reach the n will automatically stop.
то	DESIGNATE A BENEFICIARY	CALL 1-800-551-4218 OR VISIT www.W	VV457.com
I certify that the information on this Employee Signature	form is true, complete and acc	burate.	KEEP A COPY FOR YOUR RECORD RETURN COMPLETED FORM TO YOU PAYROLL/BENEFITS COORDINATO
Payroll/Benefit Coordinator Sign Coordina	tor please mail or fax a copy of this	State A a form to Office of the State Treasurer, 457 ( leston, WV 25304, Fax: 304-340-1503	gency/Political Subdivision Refirement Plus,

		Beneficiary Designation Governmental 457(b) Plan
_	te of West Virginia Retirement Plus Deferred Compensation Plan	98947-01
	My Information	
	For questions regarding this form, visit the website at www.wv457.com or contact Service Provider at 1-8 Use black or blue ink when completing this form.	00-551-4218.
Ň	Participant Information	
	Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, attende payee due to divorce or a participant with multiple accounts. Account Extension Social Security Number (	Must provide al 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  Married  Unmarried	( ) Alternate Phone Number
3	Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)	
	Primary Beneficiary Designation (Primary beneficiary designations must total 100% - percentage ca	n be made out to two decimal places.)
	<ul> <li>See the attached examples on how to complete the below beneficiary designations if the beneficiary or estate.</li> <li>%</li> </ul>	y is a non-individual, such as a trust, charity
	% of Account Balance         Primary Beneficiary Name           (/iame of individue, Trust, Charty, etc.)         (/iame of individue, Trust, Charty, etc.)           ( )         Relationship (Required - If Relationship is not provided, request with the provided, request with the provided, request with the provided of the provi	
	% of Account Balance     Primary Beneficiary Name (Name of Individual, Trust, Charity, etc.)       ()     Relationship (Required - If Relationship is not provided, request with Phone Number (Optional)       Belationship (Required - If Relationship is not provided, request with Domestic Partner	
	% of Account Balance     Primary Beneficiary Name (Name of Individual, Trust, Charity, etc.)       (	
	Contingent Beneficiary Designation (Contingent beneficiary designations must total 100% - percent	tage can be made out to two decimal places.)
	%     Contingent Beneficiary Name       (Name of Individuel, Trust, Charity, etc.)     (Name of Individuel, Trust, Charity, etc.)       (	
	%         of Account Balance         Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)           (	

#### STD FBENED 02/10/22

/22 98947-01

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	Last Name	First Name	ML		Social Security Number	98947-01 Number
в	Beneficiary Designation (Attach an a			ficiari	-	
	Contingent Beneficiary Designatio					le out to two decimal places.)
	*					
	% of Account Balance Contingent Ber (Name of Individu ( ) Phone Number (Optional)	el, Trust, Charity, etc.) Relationship (Required - If Rel			t provided, request will be rejected and randchildSiblingMy Esta	
		Domestic Partner				
С	Participant Consent for Beneficiar	y Designation (Please sign or	the Pi	vticip	ant Signature' line below.)	
	I have completed, understand and agree above beneficiary designations for my ve beneficiary designations in my account a a beneficiary or any other change that my	sted account in the event of m nd to update the beneficiary de	y death esignat	lons a	knowledge and agree that it is my	responsibility to monitor the
	If I have more than one primary beneficial be allocated to the surviving primary ben as specified. If a contingent beneficiary designate beneficiaries, amounts will be delivery to Service Provider. If any inform	eficiaries. Contingent benefici predeceases me, his or her b baid pursuant to the terms of the	enefit v be Plan	ill rec vill be	eive a benefit only if there is no sa allocated to the surviving conting oplicable law. This designation is e	urviving primary beneficiary, gent beneficiaries. If I fail to effective upon execution and
	This designation supersedes all prior des death will be divided equally. Primary an decimal points (Example: 33.33%).					
	I understand that Service Provider is requ of the Treasury ("OFAC"). As a result, Se OFAC as a specially designated national about/organizational-structure/offices/Pag	rvice Provider cannot conduct or blocked person. For more	busine	ess w	th persons in a blocked country o please access the OFAC website	r any person designated by
	Any person who presents a false	or fraudulent claim is su	bject	to c	riminal and civil penalties.	
	Participant Signature				Date (Regu	ired)
	A handwritten signature is required or	this form. An electronic sig	nature	will.		
D	Delivery Instructions					
	After all signatures have been obtaine	d, this form can be				
		OR Sent Regular Mail to: Empower Retirement PO Box 173764 Denver, CO 80217-3764		Emp 851	t Express Mail to: ower Retirement 5 E. Orchard Road enwood Village, CO 80111	

Securities, when presented, are offered and/or distributed by GWFS Equities, Inc., Member FINRA/SIPC. GWFS is an affiliate of Empower Retirement, LLC; Great-West Funds, Inc.; and registered investment adviser, Advised Assets Group, LLC. This material is for informational purposes only and is not intended to provide investment, legal or tax recommendations or advice.

# 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





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



Securion Financial is the marketing name for Securian Financial Group, Inc. and its affiliates, insurance products are issued by its offiliated insurance companies, including Ministoria Utle Insurance Company and Securian Life insurance Company, o New York authorized insurer. Securities and investment advacry services offered through SecurianFinancial Services, inc., registered investment advacro, memore FINAR/SIPC.

191979 10-2018 DOFU II-2018 632015



#### 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: Minnesola Life Insurance Company

# Protect your family's financial future



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:

Guaranteed coverage - get quick coverage

with no medical exam or health questions

also known as evidence of insurability (EOI).

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,

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.

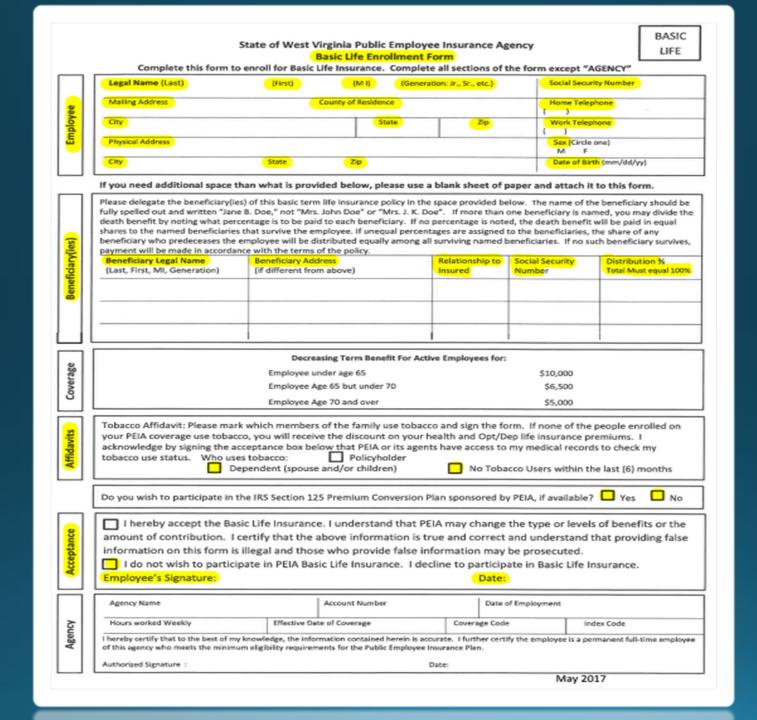


#### How do I learn more?

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.





	Complete this fo		lealth Bene	ublic Employee fits Enrollmen ge. Complete a	t Forn	n		GENCY"	HEALT
٦	Legal Name (Lest)	(First)		(MI) (Generat	ion: Jr.,	Sr., etc.)	Social Secur	ity Number	
	Mailing Address		County of Res	idence			Home Telep	hone	
	City	State	2	ip			( ) Work Telepi	hone	
	Physical Address						( ) Sex (Circle	one)	
L	City	State	20				M F	rth (mm/dd/y)	4
							1		
٦	If you need additional s	pace than what i	s provided I	below, please u	ise a k	lank sheet	of paper and	attach it to	o this form
	If spouse is currently insured		older, please e	-	-	-	Le la la la la		
	Legal Name (Last, First, MI,Generation)	Address (if different from	above}	Relationship	Sex	Birth Date	Social Security Number	Other H Insuran (Plan Na	ce
L	enrolling for:	<mark>ect One)</mark> I am		ase indicate the dside the plan of	ption y		are enrolling t	by checking	the box
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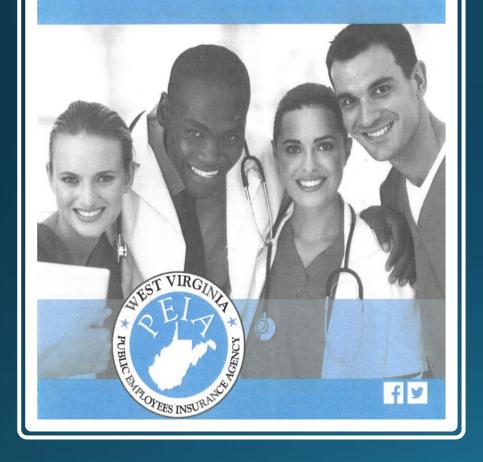
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		e of West Virginia Public Emplo Change In Status F Complete this form to Change the sta Complete all sections of the form	tus of your coverage.
	Marriage	Death of a dependent	Open Enrollment
ason	Divorce	Birth of a Child	Affordable Care Act
ווחלפטע כחזפור ווו בקוופוים	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
-0	Adoption	Beginning or end of a dependent's employment	Other (Please Specify):
	certain circumstances. You will be PEIA. You will have a limited amo COBRA premiums include both th premiums paid by active employe HealthSmart at 1-888-440-7342.	e sent a notification with the necessary app ount of time to elcect continuation of cover- e employer and employee share of the pre- res. The premiums are printed in the Shopp	inued coverage to qualified policyholders or dependents under klcations by HealthSmart Solutions, who administers COBRA for age. mium, as well as an adminstrative fee, so they are higher than neer's Guide each year. For further information, you may contact is, please provide the dependent's mailing address below :
	your PEIA coverage use tobacc acknowledge by signing the ac tobacco use status. Who uses tobacco: Pol	co, you will receive the discount on you coptance box below that PEIA or its ag	acco and sign the form. If none of the people enrolled on ir health and Opt/Dep life insurance premiums. I ents have access to my medical records to check my dent (spouse and/or children) ths
weeptaure	or the amount of contribution information on this form is ille my covered dependents, to th needed to process claims, det	I certify that the above information i egal and those who provide false inform re release to PEIA and to the plan I have	lerstand that PEIA may change the type or levels of benefits is true and correct and understand that providing false mation may be prosecuted. I hereby consent, for myself and e selected, all medical and prescription drug information vestigate complaints, assess quality of care, evaluate plan int of claims or health care operations. Date:
٦	Agency Name		Account Number
	Effective Date of Status Chan	ge	Index Code
			I ontained herein is accurate. I further certify the employee is mum eligibility requirements for the Public Employee
-	Insurance Plan.		



Open Enrollment April 2 - May 15, 2021 | July 1, 2021 - June 30, 2022

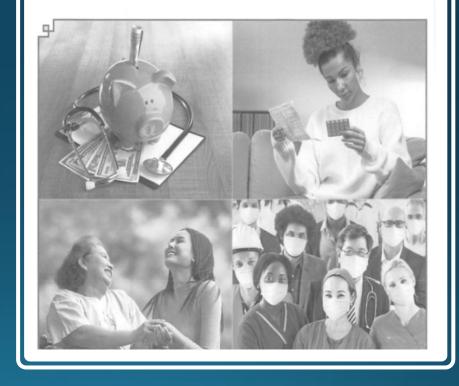


## **Shopper's Guide**



#### 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
- <u>DIVORCE</u>: 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. <u>See page 33 – Voluntary Termination of Benefits</u>.

#### **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 PLANC

- 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



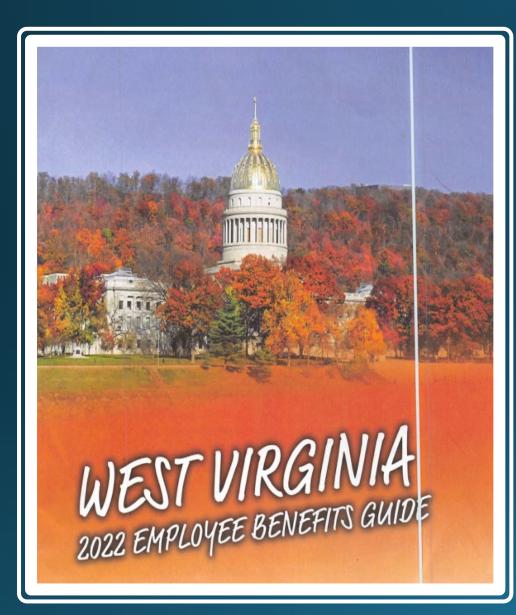


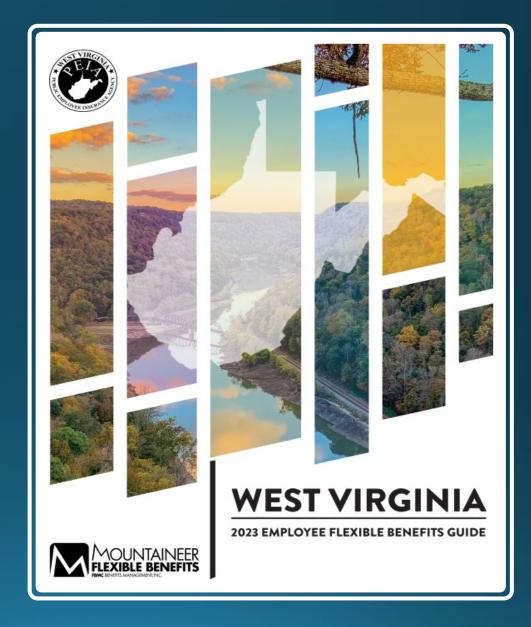
# **BENEFITS MANAGEMENT**

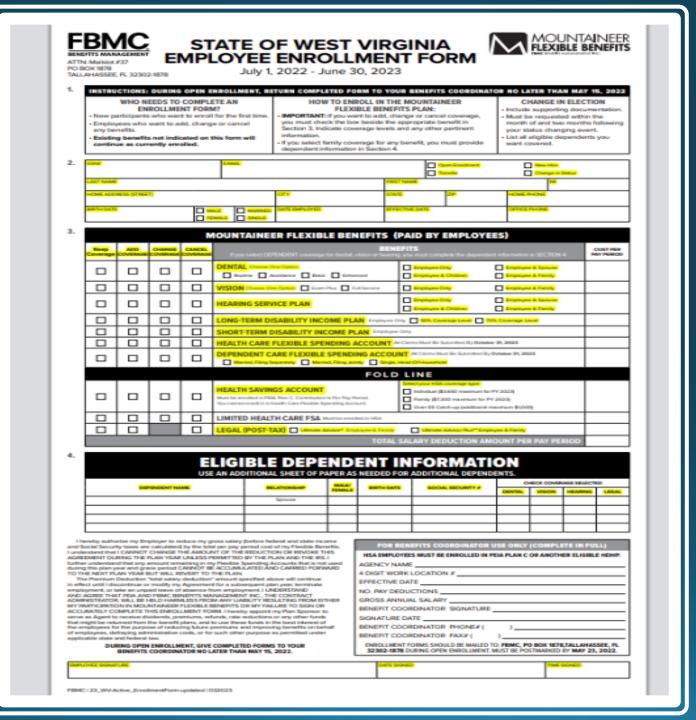


# EMPLOYEE PAID BENEFITS INCLUDING:

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







# 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







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 & MILEX

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#### 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 5<sup>a</sup> 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 5<sup>th</sup> of each month. Facility\_\_\_\_\_.

PEIA insurance \$\_\_\_\_\_\_total per month and if missing  $\frac{1}{2}$  month premium \$\_\_\_\_\_\_(make check out to DAS).

Mt. Flex insurance  $\$ \_\_\_\_\_\_total per month and if missing  $\frac{1}{2}$  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 2<sup>nd</sup> 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 <u>must pay back all missing premiums</u> or <u>wait until the next</u> <u>Open Enrollment</u> 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).

_		<u> </u>	
Empl	OVER C	Signature:	
CINP		original and	

Date: \_\_\_\_

SD-11/20/2020

Benefits Management	STATE OF WEST VIRGINIA Active Employees Personal Pay Summary Form
gency:	
mployee Name:	
ast Four Digits of Ss# ⊸	FBMC 4-Digit Work Location
:heck #	Check Dollar Amount
	return this completed document and payment to your local
eenefits Coordinator for o coopted unless accomp ignature is required.	istribution to FBMC. Please note: payments will NOT be anied by this completed document. Benefit Coordinator
eenefits Coordinator for o coopted unless accomp ignature is required.	bistribution to FBMC. Please note: payments will NOT be anied by this completed document. Benefit Coordinator Date:
enefits Coordinator for o ccepted unless accomp ignature is required. enefit Coordinator:	istribution to FBMC. Please note: payments will NOT be anied by this completed document. Benefit Coordinator
enefits Coordinator for o coopted unless accompa ignature is required. enefit Coordinator: enefit Coordinator Signa	bistribution to FBMC. Please note: payments will NOT be anied by this completed document. Benefit Coordinator Date:
enefits Coordinator for o ccepted unless accompa ignature is required. enefit Coordinator: enefit Coordinator Signa W	AKE CHECKS PAYABLE TO:

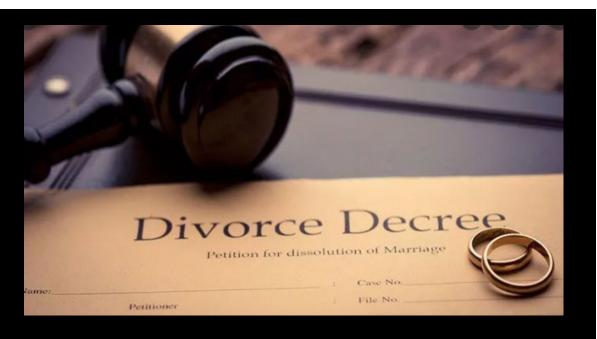
### SELF-PAYMENT TRACKING LOG

- \* 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 <u>Sharon.K.Withrow@wv.gov</u> 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

C	DEPARTN	ATE OF WEST VIRGIN IENT OF MILITARY AFFAIRS & PUBLIC CORRECTIONS AND REHL	SAFETY E C
	ANDY, CAMS, CFE T SECRETARY	BETSY C. JIVIDEN COMMISSIONER	DONALD AMES SUPERINTENDENT
		ميوند 	
			f
TO:			
FROM:	· -		
DATE:	29 August 2019		
RE:	Divorce final February 2019		

\* <sup>2</sup>·<sup>1</sup>-a you should have termed your spouse once divorce was final on February 22<sup>nd</sup> 2019, this would have been effective March 1<sup>st</sup> 2019, you failed to report this Change In Status until August 29<sup>th</sup> 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.

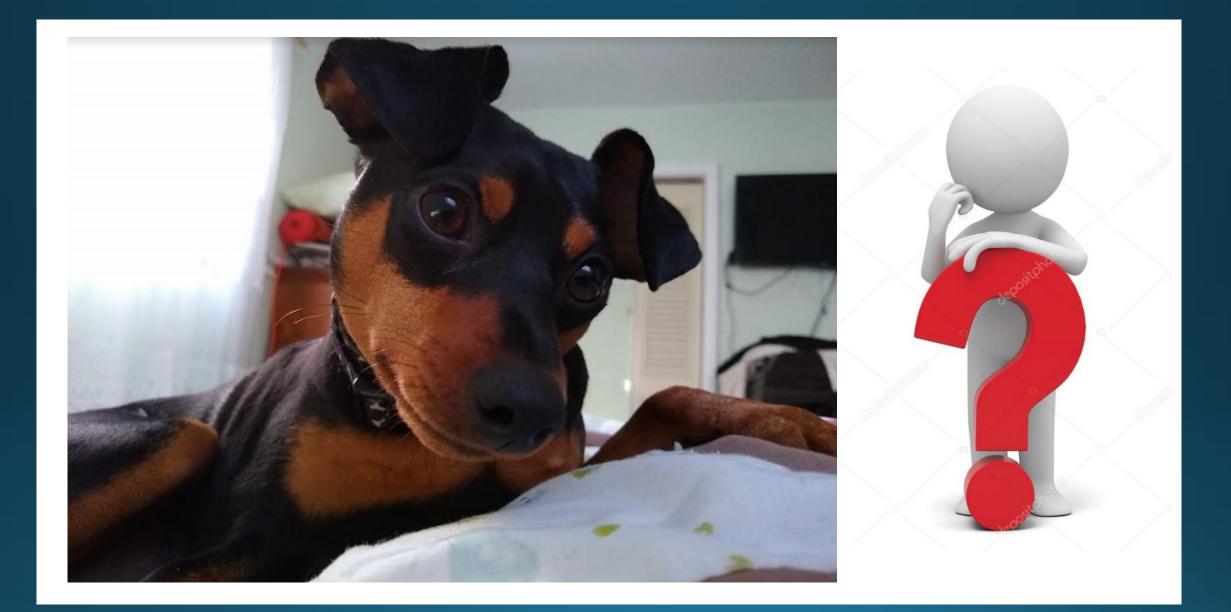
I have broken it down to show you the difference:

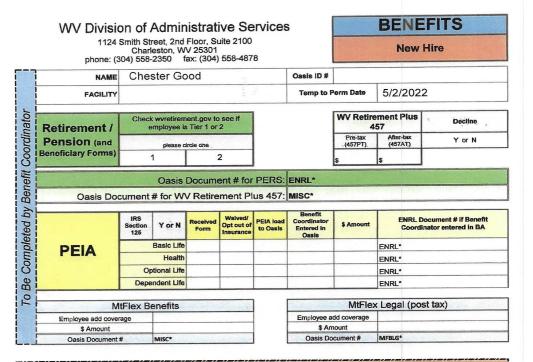
	ployer paid Family	Employer should have paid for Employee Children
Mar. 2019	\$788.00	\$411.00
Apr. 2019	\$788.00	\$411.00
May 2019	\$788.00	\$411.00
June 2019	\$788.00	\$411.00
July 2019	\$803.00	\$426.00
Aug. 2019	\$803.00	\$426.00
_	\$4758.00	\$2496.00

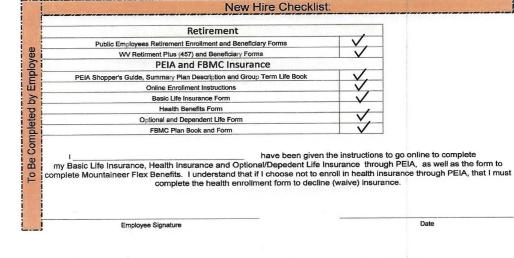
Difference being \$2262.00 owed to Employer

I \_\_\_\_\_ 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







### **SCENARIO 1**



- **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

### CP-

#### 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.

Full Name			SSN		Date of Birth	Teleph	one Number
Festus Hagen					7-2-1916		
Gender	Member Mailing Address			City		State	Zip Code
Female Male	Main Street-Jail H	ouse		Dod	dge City	KS	67801
mployer Name			Date o	f Hire wit	th Current Employer	Job Position	
Dodge City Corre	ctional Central		5-2-	2022		Deputy	Sheriff
Position Status		Scheduled Hour	s Per Day Payoll Fr	equency			
Full Time Ele	cted Part Time Ter	<sup>mporary</sup> 24/7		eekly [	Bi-Weekly	Semi-Mo	nthly 🖌 Monthly
Type of Rate of Pay		Rate of Pay	Employment Pay	ment Ty	pe		
Daily Hourly	Monthly 🖌 Yearly	\$ 120,000.00	П н	ourly	✓ Salaried	Per	Diem/Daily
Are you currently retired u	under any of the State's Reti	rement Systems? No	<b>√</b> Yes	Have yo	u previously contrib	uted to the	
If Yes, please provide t	he employer:	_		Public E	mployees Retiremen	it System? *	
Name of Spouse			Spouse Date of B	irth	Spouse SSN		
April Hagen			7-2-1918		202-02-202	2	

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 <u>NOT</u> 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.

ı	wish	to	participate	in	PERS

Date \_\_\_\_

Date:

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 \_\_\_\_\_

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:





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

• 1<sup>st</sup> 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.

E 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 Ben	eficiary	55N	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		
<sup>City</sup> Dodge City	State KS	Zip Code 12878
Employage City CC	Work Phone	Home Phone
Member Signature		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 W	√ 25301	Witness Telephone 304-558-2350
Once accepted by the CPRB, this form superso	edes any and all prior Pre-Retirement Beneficiary Desig	nations for you under PERS.
CPRB use only: Verify correct section completed based on PERS c Verify member is not a PERS retiree.	redited service and original hire date.	Initial Date
	Page 2 of 8	
and the second se		WVPF0080 March 1

### **SCENARIO 3**

• 2<sup>nd</sup> 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**

RETIREMENT PIL			EST VIRGINIA PENSATION PLAN
BUILDING A BRIDGE TO YOUR FUTU	J.		DN AGREEMENT 5/3/2021
Check / the appropriate transaction belo		Rev.	5/3/2021
Auto Enrollment	Agency Transfer	Suspend Salary	Deferral Name/Address Chan
New Enrollment	Increase/Restart Salary I	Deferral Age 50 Catchur	Termination / Retirer
Decline Automatic Enrollment	Decrease Salary Deferral	I Special Catchu	p
	PARTICI	IPANT INFORMATION	
NAME: LAST Pheeters	FIRST Louie	MIDDLE	1-1-1916
ADDRESS: STREET Horse Sta	ble		Date of Birth
CITY Dodge City	STATE KS	ZIP 67801	Social Security #
			5-2-2022
AGENCY / POLITICAL SUBDIVISIO	N		Date of Employment
PHONE: HOME	_ CELL	WORK	Former Plan Participant? Check
EMAIL			Agency / Political Subdivision Wo
	DEF.	ERRAL ELECTION	
Before Tax Contributions: I elect to con \$100 \vee 150 \$50 Both Contributions: I elect to contribute	\$25 \$10	Other (write in amount)	\$% of sa
\$100 🖌 \$50	\$25 \$10	Other (write in amount) priod of my compensation after-tax	\$% of sate as a designated Roth contribution to the
\$100   \$50   Roth Contributions: I elect to contribute	\$25   \$10     the following amount per pay per     \$25   \$10     ffective the first day of the month	Other (write in amount) eriod of my compensation after-tao Other (write in amount) following the completion of this fo	<pre>\$ or% of s x as a designated Roth contribution to the \$ or% of s prm or the pay</pre>
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be element	\$25   \$10     the following amount per pay per     \$25   \$10     ffective the first day of the month	Other (write in amount) eriod of my compensation after-tao Other (write in amount) following the completion of this fo	<pre>\$ or% of sa as a designated Roth contribution to the \$ or% of sa prm or the pay</pre>
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be eledate indicated on the designated line, exclosion following receipt of this form.         EMPLOYEE AGREEMENT	\$25 \$10 the following amount per pay per \$25 \$10 ffective the first day of the month cept suspending your salary defe	Other (write in amount) eriod of my compensation after-tax Other (write in amount) following the completion of this fo erral will be effective the first availa	for% of size     as a designated Roth contribution to the     s or% of size     orm or the pay     able paydate     Effective D  PLAN / AUTOMATIC ENROLLMENT
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be ed date indicated on the designated line, exc following receipt of this form.         Effective Date: The sagreement will be ed date indicated on the designated line, exc following receipt of this form.         EMPLOYEE AGREEMENT         The State of West Virginia has establise employees. The Plan provides that elige Plan upon executing and filing a Partic Plan and an amount equal to \$10 per per Plan. If you do not want to participate in Benefits Coordinator within 30 days of The employee acknowledges the follow 1. I elect to participate in the Plan and 2. I agree that all rights to the deferments. I agree that the elections indicated maximum dollar amount allowed upon the same of the employee acknowledges the follow 1. I agree that the elections indicated maximum dollar amount allowed upon the same of the	\$25 \$10 the following amount per pay per \$25 \$10 ffective the first day of the month cept suspending your salary defe <u>NT TO PARTICIPATE IN 457 II</u> hed an Internal Revenue Code ible employees may elect to jo cipation Agreement with the Sta vay period will be deducted from the Plan at this time, please of your date of employment. If your ving: d agree to defer compensation de compensation shall be gove d above will remain in effect unti inder the Plan and Code. If the th any Internal Revenue Code	Other (write in amount) priod of my compensation after-tax Other (write in amount) following the completion of this for priod of the completion of this for priod will be effective the first availant DEFERRED COMPENSATION a Section 457(b) Deferred Comp in and become participants in the tate. Employees hired on or after m your pay and deposited into a check the "Decline Automatic Er- pour elect this option, you may che- the the Plan in accordance with med by the terms and condition til later changed or revoked by r latter occurs, my salary deferred	for% of size     as a designated Roth contribution to the     for% of size     as a designated Roth contribution to the     for% of size     for% of si
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be ed date indicated on the designated line, exc following receipt of this form.         Effective Date: The sagreement will be ed date indicated on the designated line, exc following receipt of this form.         EMPLOYEE AGREEMENT         The State of West Virginia has establis employees. The Plan provides that elige Plan) upon executing and filing a Participate in Benefits Coordinator within 30 days of The employee acknowledges the follow 1. I elect to participate in the Plan and 2. I agree that all rights to the deferred. I agree that the elections indicated maximum dollar amount allowed up enalties that I may incur as a results.	\$25 \$10 the following amount per pay per \$25 \$10 ffective the first day of the month cept suspending your salary defe <b>NT TO PARTICIPATE IN 457 I</b> hed an Internal Revenue Code ible employees may elect to jo cipation Agreement with the Sta vay period will be deducted from the Plan at this time, please of your date of employment. If your ving: d agree to defer compensation ad compensation shall be gove a doove will remain in effect und inder the Plan and Code. If the th any Internal Revenue Code ult of excess contributions.	Other (write in amount) eriod of my compensation after-tax Other (write in amount) following the completion of this for erral will be effective the first availar DEFERRED COMPENSATION a Section 457(b) Deferred Comp in and become participants in the ate. Employees hired on or after my our pay and deposited into a check the "Decline Automatic Er- bue lect this option, you may chu h to the Plan in accordance with med by the terms and condition til later changed or revoked by r latter occurs, my salary deferrer deferral limits and that I may be	\$ or% of sizes as a designated Roth contribution to the star as a designated Roth contribution to the pay able paydate <b>Effective D</b> . <b>Effective D</b> . <b>PLAN / AUTOMATIC ENROLLMENT</b> bensation Plan (Plan) for the benefit of ine Plan (subject to the limitations estab July 1, 2007 will be automatically enror n account in your name, to be invested brollment" option above and return the floose to enroll in the Plan at a later date the Plan and Internal Revenue Code (It is of the Plan and Code. The or my contributions during any year lefection will automatically stop. The sponsible for any costs, including taken the plan and costs. The sponsible for any costs, including taken the plan and costs.
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be ed date indicated on the designated line, exc following receipt of this form.         Effective Date: The sagreement will be ed date indicated on the designated line, exc following receipt of this form.         EMPLOYEE AGREEMENT         The State of West Virginia has establis employees. The Plan provides that elige Plan) upon executing and filing a Participate in Benefits Coordinator within 30 days of The employee acknowledges the follow 1. I elect to participate in the Plan and 2. I agree that all rights to the deferred. I agree that the elections indicated maximum dollar amount allowed up enalties that I may incur as a results.	\$25 \$10 the following amount per pay per \$25 \$10 ffective the first day of the month cept suspending your salary defe <u>NT TO PARTICIPATE IN 457 II</u> hed an Internal Revenue Code ible employees may elect to jo cipation Agreement with the Sta vay period will be deducted from in the Plan at this time, please of your date of employment. If your ving: d agree to defer compensation de compensation shall be gove d above will remain in effect unti inder the Plan and Code. If the th any Internal Revenue Code ult of excess contributions. ESIGNATE A BENEFICIARY of	Other (write in amount) eriod of my compensation after-tax Other (write in amount) following the completion of this for erral will be effective the first availar DEFERRED COMPENSATION a Section 457(b) Deferred Comp in and become participants in th ate. Employees hired on or after my our pay and deposited into a check the "Decline Automatic Er- bu elect this option, you may che h to the Plan in accordance with med by the terms and condition til later changed or revoked by r latter occurs, my salary deferrer deferral limits and that I may be CALL 1-800-551-4218 OR VIST	for% of size     as a designated Roth contribution to the     for% of size     as a designated Roth contribution to the     for% of size     for% of size     for% of size     for% of size     for the pay     able paydate         Effective D     PLAN / AUTOMATIC ENROLLMENT     prensation Plan (Plan) for the benefit of it     the Plan (subject to the limitations estable     July 1, 2007 will be automatically enror     n account in your name, to be invested     the Plan and Internal Revenue Code ((     is of the Plan and Code.     ne or my contributions during any year     l election will automatically stop.     responsible for any costs, including ta     Tww.WV457.com     KEEP A COPY FOR YOU
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be ed date indicated on the designated line, exc following receipt of this form.         Effective Date: The agreement will be ed date indicated on the designated line, exc following receipt of this form.         EMPLOYEE AGREEMENT         The State of West Virginia has establise employees. The Plan provides that eligp Plan upon executing and filing a Partic Plan and an amount equal to \$10 per per Plan. If you do not want to participate in Benefits Coordinator within 30 days of The employee acknowledges the follow 1. I elect to participate in the Plan and 2. I agree that all rights to the defermer 3. I agree that all rights to the defermer 3. I agree that the elections indicated maximum dollar amount allowed ut 4. It is my responsibility to comply with penalties that I may incur as a rest to D	\$25 \$10 the following amount per pay per \$25 \$10 ffective the first day of the month cept suspending your salary defe <u>NT TO PARTICIPATE IN 457 II</u> hed an Internal Revenue Code ible employees may elect to jo cipation Agreement with the Sta vay period will be deducted from in the Plan at this time, please of your date of employment. If your ving: d agree to defer compensation de compensation shall be gove d above will remain in effect unti inder the Plan and Code. If the th any Internal Revenue Code ult of excess contributions. ESIGNATE A BENEFICIARY of	Other (write in amount) eriod of my compensation after-tax Other (write in amount) following the completion of this for erral will be effective the first availar DEFERRED COMPENSATION a Section 457(b) Deferred Comp in and become participants in th ate. Employees hired on or after my our pay and deposited into a check the "Decline Automatic Er- ou elect this option, you may che h to the Plan in accordance with med by the terms and condition til later changed or revoked by r latter occurs, my salary deferrer deferral limits and that I may be CALL 1-800-551-4218 OR VIST	\$ or% of sate as a designated Roth contribution to the \$ or% of sate proverse of sate able paydate
\$100       \$50         Roth Contributions: I elect to contribute         \$100       \$50         Effective Date: This agreement will be edite indicated on the designated line, excipation of this form.         Effective Date: This agreement will be edite indicated on the designated line, excipation of this form.         EMPLOYEE AGREEMENT         The State of West Virginia has establise employees. The Plan provides that eligp Plan upon executing and filing a Participate in Benefits Coordinator within 30 days of The employee acknowledges the follow         1 elect to participate in the Plan and a lights to the deferres         a lagree that all rights to the deferres         4. It is my responsibility to comply with penalties that I may incur as a ress         TO D         I certify that the information on this formation	\$25 \$10 the following amount per pay per \$25 \$10 ffective the first day of the month cept suspending your salary defe NT TO PARTICIPATE IN 457 If hed an Internal Revenue Code lible employees may elect to jo cipation Agreement with the Sta vay period will be deducted from in the Plan at this time, please of your date of employment. If your your date of employment. If your your date of defer compensation de compensation shall be gove a doove will remain in effect unti under the Plan and Code. If the th any Internal Revenue Code ult of excess contributions. ESIGNATE A BENEFICIARY ( orm is true, complete and account Date	Other (write in amount) priod of my compensation after-tax Other (write in amount) following the completion of this for- priod of the completion of this for- priod the effective the first availant DEFERRED COMPENSATION a Section 457(b) Deferred Comp- in and become participants in that a comparticipants in that tate. Employees hired on or after my your pay and deposited into a check the "Decline Automatic Er- pou elect this option, you may che- the to the Plan in accordance with med by the terms and condition it latter changed or revoked by re- latter occurs, my salary deferrat deferral limits and that I may be CALL 1-800-551-4218 OR VISIT- surate.	\$ or% of si as a designated Roth contribution to the \$ or% of si prm or the pay able paydate PLAN / AUTOMATIC ENROLLMENT rensation Plan (Plan) for the benefit of in the Plan (subject to the limitations estable July 1, 2007 will be automatically enror n account in your name, to be invested brollment" option above and return the form pose to enroll in the Plan at a later date the Plan and Internal Revenue Code (form is of the Plan and Code. me or my contributions during any year l election will automatically stop. responsible for any costs, including ta T www.WV457.com



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

State of West Virginia Public Employee Insurance Agen	су
Basic Life Enrollment Form	

BASIC	
LIFE	

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

/ee	Legal Name (Last) Dillon Mailing Address Main Street-Jail House	(First) Matt	(M I) J County of Residence	(Generation: Jr., Sr., etc.)	Social Security Number 019-14-1919 Home Telephone ( )
Employee	<sup>City</sup> Dodge City		State KS	67801	Work Telephone ( )
<b></b>	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.

y(ies)	fully spelled out and written "Jan death benefit by noting what per shares to the named beneficiarie: beneficiary who predeceases the payment will be made in accorda		I. K. Doe". If more than If no percentage is note ercentages are assigned ong all surviving named I	one beneficiary is n ed, the death benefi to the beneficiaries	amed, you may divide the it will be paid in equal , the share of any
Beneficiary(ies)	Beneficiary Legal Name (Last, First, Ml, Generation)	Beneficiary Address (if different from above)	Relationship to Insured	Social Security Number	Distribution % Total Must equal 100%
		Decreasing Term Benefit Fo	or Active Employees for:		
Coverage		Employee under age 65 Employee Age 65 but under 70		\$10,000 \$6,500	
0		Employee Age 70 and over		\$5,000	
	Tobacco Affidavit: Please mar	k which members of the family use t	obacco and sign the fo	orm. If none of th	e people enrolled on
Affidavits	your PEIA coverage use tobac acknowledge by signing the a tobacco use status. Who use	k which members of the family use t co, you will receive the discount on y cceptance box below that PEIA or its es tobacco: Policyholder ependent (spouse and/or children)	your health and Opt/D agents have access to	ep life insurance p my medical recor	premiums. I
Affidavits	your PEIA coverage use tobac acknowledge by signing the a tobacco use status. Who use D	co, you will receive the discount on y cceptance box below that PEIA or its es tobacco: Policyholder	your health and Opt/D agents have access to No Toba	ep life insurance p my medical recor acco Users within	oremiums. I rds to check my the last (6) months
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Acceptance	your PEIA coverage use tobac acknowledge by signing the a tobacco use status. Who use Do you wish to participate in the amount of contribution. I information on this form is I do not wish to partici Employee's Signature: Agency Name Dodge City CC	co, you will receive the discount on y cceptance box below that PEIA or its as tobacco: Policyholder ependent (spouse and/or children) the IRS Section 125 Premium Convers sic Life Insurance. I understand th certify that the above information illegal and those who provide fal	vour health and Opt/D agents have access to No Toba sion Plan sponsored b nat PEIA may change n is true and correct ise information may I decline to particip Date:	ep life insurance p my medical recor- acco Users within y PEIA, if available the type or leve and understand be prosecuted. ate in Basic Life	eremiums. I rds to check my the last (6) months ? Yes No Pressor No rels of benefits or the I that providing false
Acceptance	your PEIA coverage use tobac acknowledge by signing the a tobacco use status. Who use Do you wish to participate in the amount of contribution. I information on this form is I do not wish to partici Employee's Signature:	co, you will receive the discount on y cceptance box below that PEIA or its as tobacco: Policyholder ependent (spouse and/or children) the IRS Section 125 Premium Convers sic Life Insurance. I understand th certify that the above information illegal and those who provide fal pate in PEIA Basic Life Insurance. Account Number 7-2022-02-02 Effective Date of Coverage	vour health and Opt/D agents have access to No Toba sion Plan sponsored b nat PEIA may change n is true and correct lse information may I decline to particip Date: Coverage Code	ep life insurance p my medical recorn acco Users within the y PEIA, if available the type or leve and understand be prosecuted. ate in Basic Life of Employment 5-2-2022	oremiums. I rds to check my the last (6) months Present the last (6) mo
	your PEIA coverage use tobac acknowledge by signing the a tobacco use status. Who us Do you wish to participate in the amount of contribution. I information on this form is I do not wish to partici Employee's Signature: Agency Name Dodge City CC Hours worked Weekly 24/7 I hereby certify that to the best of m of this agency who meets the minim	co, you will receive the discount on y cceptance box below that PEIA or its as tobacco: Policyholder ependent (spouse and/or children) the IRS Section 125 Premium Convers sic Life Insurance. I understand th certify that the above information tillegal and those who provide fal pate in PEIA Basic Life Insurance. Account Number 7-2022-02-02 Effective Date of Coverage	vour health and Opt/D agents have access to No Toba sion Plan sponsored b mat PEIA may change n is true and correct lse information may I decline to particip Date: Date Coverage Code	ep life insurance p my medical recorn acco Users within the y PEIA, if available the type or leve and understand be prosecuted. ate in Basic Life of Employment 5-2-2022	oremiums. I rds to check my the last (6) months Present the last (6) mo

### **SCENARIO 5**



- 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

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

HEALTH	
HEALTH	

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

Legal Name (Last) Dillon	(First) Matt	(MI) (Ger	neration: Jr., Sr., etc.)	Social Security Number 202-16-1616
Mailing Address 111 Main Street		County of Residence		Home Telephone ( )
Dodge City	State KS	<sup>zip</sup> 67801		Work Telephone ( )
Physical Address Jail House				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.

Legal Name (Last, First, MI,Generation)	Address (if different from above	e)	Relationship	Sex	Birth Date	Social Security Number	Other Health Insurance (Plan Name)
Coverage Selection (Sele enrolling for: Employee Only Employee/Child(re Family		ase indicate the side the plan o PEIA PPB P PEIA PPB P PEIA PPB P PEIA PPB P	otion y lan A lan B lan C	rou choose:	are enrolling by The Health Plan The Health Plan The Health Plan	HMO Plan B	

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:

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.

Matt Dillon

Affidavits

Acceptance

Employee's Signature:

Date:	5/2	2/2022
La catta de la companya de la catta de	The second se	-

	Agency Name Dodge City CC	Account Number 7-2022-02-02	Date of Employn 5-2-202	
	Hours worked Weekly 24/7	Effective Date of Coverage 6-1-2022	Index Code	Coverage Code
0	I hereby certify that to the best of my know employee of this agency who meets the m	wledge, the information contained here inimum eligibility requirements for the	in is accurate. I further Public Employee Insura	certify the employee is a permanent nce Plan.
	Authorized Signature : Mark Ber	ckener Da	te: 5-2-2022	

### **SCENARIO 6**



### 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



PO BOX 1878

### STATE OF WEST VIRGINIA **EMPLOYEE ENROLLMENT FORM**

TALLAHASSEE, FL 32302-1878

July 1, 2021 - June 30, 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.
---	---	---

55N#	E-M	AIL			Open Enrollment Transfer	Nev	v Hire inge in Status
LAST NAME Dillon				FIRST NAME Matt			м
HOME ADDRESS [STREET]			Dodge City	STATE KS	<sup>ZIP</sup> 67801	HOME PHONE	
BIRTH DATE 2-14-1916	FEMALE		DATE EMPLOYED 5-2-2022	EFFECTIVE DATE 6-1-2022		OFFICE PHON	IE

Keep Coverage	ADD COVERAGE	CHANGE	CANCEL		BENEFITS If you select DEPENDENT coverage for dental, vision or hearing, you must complete the dependent information in SECTION 4.					
	7			DENTAL Choose One Option:	Employee Only	Employee & Spouse				
	7			VISION Choose One Option: Exam Plus Full Service	Employee Only	Employee & Family				
				IEARING SERVICE PLAN						
				LONG-TERM DISABILITY INCOME PLAN Employe	ONG-TERM DISABILITY INCOME PLAN Employee Only 50% Coverage Level 70% Coverage Level					
				SHORT-TERM DISABILITY INCOME PLAN Emplo	SHORT-TERM DISABILITY INCOME PLAN Employee Only					
				HEALTH CARE FLEXIBLE SPENDING ACCOUNT	All Claims Must Be Submitted By Oc	tober 31, 2022.				
				DEPENDENT CARE FLEXIBLE SPENDING ACCC		d By October 31, 2022.				
				Select your HSA coverage type:     Select your HSA coverage type:     Individual \$3,660 maximum for PY 2021)     Individual \$3,660 maximum for PY 2021)     Family \$17200 maximum for PY 2021)     Constructions Par Pay Period     You cannot enrol in a Health Care FloxIble Spending Account.     Over 55 Cache by deditional maximum \$1,000)						
				LIMITED HEALTH CARE FSA Must be enrolled in HSA.						
		and the second		LEGAL (POST-TAX) Utimate Advisor® Employee & Family Utimate Advisor Plus <sup>M</sup> Employee & Family						

MOUNTAINEER

	GIBLE DEP ADDITIONAL SHEET OF							
DEPENDENT NAME	RELATIONSHIP	RELATIONSHIP MALE/ BIRTH DATE SOCIAL SECURIT	SOCIAL SECURITY #	CI	CHECK COVERAGE SELECTED			
		FEMALE	DIATEDRIE	SOCIAL SECONTT #	DENTAL	L VISION	HEARING	LEGAL
	Spouse							
					1			

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 Pickble Benefits. Lunderstand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE FLANN 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 CARRED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE FLAN in effect until decontinuin to that alsely deduction: amount specified above will continue employment, or take an unpaid leave of absence for angulogment. I DMI year, taminate employment, or take an unpaid leave of absence for angulogment I DMI year. ADM AGREET HAT FEBA AND FEMC EINERTER TO MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARNLESS FROM ANY LURLITY RESULTING FROM EFTHER. I hereby authorize my Employer to reduce my gross salary (before federal and state income

ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LUABILITY RESULTING FROM ETHER MY PARTICIPATION IN MOUNTAINEER PLEXIBLE 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, permiums, 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 defraving 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.

EMPLOYEE SIGNATURE

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.
DATE SIGNED TIME SIGNED

### **SCENARIO 7**

- 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

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

CIS

## **SCENARIO 8 PAGE 1**

		Complete this form to C Complete all section	hange the statu s of the form ex	s of your cept "AG	coverage. GENCY"		
	Full Legal Name (Last) Dillon	(First) Matt	(MI) (Gene	ration: J	r., Sr., etc.)	Social Security	
oyee	Mailing Address 111 Main Street		Home Telepho ( )				
Employee	City Dodge City Physical Address	<sup>State</sup> KS	Zip 673	301		Work Telephor ( )	
	City	State				Sex (Circle one M F Date of Birth	
	Dodge City	KS	6780	1		2-14-1916	(1111)/00/99)
Change	<ul> <li>Name Change: Polic</li> <li>Add Dependents to: Complete Deperrequired for life</li> <li>Remove Dependents fr</li> <li>Change in Health Coverage</li> <li>Add Health Coverage</li> <li>Drop Health Coverage.</li> <li>Tobacco Status Change</li> <li>Other, Please Specify_For each Qualifying event For each Qualifying eve</li></ul>	ndent information below. insurance. com: Health Dependent C rage from Plan PEIA Plan A I The Health Plan HMO Pl Keep Life Insurance Only. Th	Dptional Life [ If not in the ini Dptional Life: [ to Plan PEIA Plan B an A  The his terminates He To add a deper restions about n itten across the nust update that	Plan 1 ial enro Plan 1 Plan 1 Health Pl ealth Cov dent, PE ecessary top of all plan see	Plan 2 Plan 2 Plan 2 PEIA Plan 2 PEIA Plan C an HMO Pla verage for Po ilA requires of documentation documentation	Plan 3 Plan iod, Evidence of Plan 3 Plan 4  Plan 3 Plan 4  PEIA Plan 1  PEIA Plan 1  Dicyholder and al documentation to tion. The membe submitted to PEI	4 Plan 5 Insurability is Plan 5 th Plan PPO Plan C I dependents. substantiate legal r's name, social A. MC enrollment
ation	If spouse is currently insure please enter their Social Se Legal Name (Last, First, MI,Generation)	ed by PEIA as a policyholder, curity Number Address (if different from above)	Relationship		and the second	Social Security Number	Other Health Insurance (Plan Name)
Dependent Information	Dillon-Russell, Kitty	same	Spouse	F 2	2-3-1920		
Depe							

### PEIA Change In Status Form---Matt Dillon

1<sup>st</sup> 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

July 2021

	Marriage	Death of a dependent	Open Enrollment					
eason	Divorce	Birth of a Child	Affordable Care Act					
Change in Status Reason	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					
Change	Adoption	Beginning or end of a dependent's employment	Other (Please Specify):					
COBRA	certain circumstances. You will be PEIA. You will have a limited amou COBRA premiums include both the premiums paid by active employee HealthSmart at 1-888-440-7342. If the dependent's address is di Dependent Name: Street Name:	sent a notification with the necessary appl nt of time to elcect continuation of covera, employer and employee share of the pren s. The premiums are printed in the Shoppe	nium, as well as an adminstrative fee, so they are higher than er's Guide each year. For further information, you may contact s, please provide the dependent's mailing address below:					
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 Name Dodge City ( Effective Date of Status Chang		Account Number 7-720-22-22					
Agency	7-1-2022 I hereby certify that to the bes	t of my knowledge, the information co	10 Intained herein is accurate. I further certify the employee is num eligibility requirements for the Public Employee					
	Authorized Signature:	lark Beckner	Date: 6-15-2022					

## **SCENARIO 8 PAGE 2**

## **PEIA Change In Status Form---Matt Dillon**

2<sup>nd</sup> page

(1) Didn't fill out the Tobacco Affidavit

(2) Didn't mark the Acceptance

(3) Missing Policyholder's Signature and Date

