Retiree
BL/Health

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

Retirement Health Benefits and Basic Life Insurance Enrollment Form Instructions

Retiree: Complete all demographic information. Use your full **LEGAL** name. The 'Generation' area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III etc.

The Medicare ID Number can be found on your red, white, and blue Medicare card. The number is required for continued coverage when you reach Medicare age. If you are not yet eligible for Medicare, please send PEIA a copy of your Medicare card when you enroll for Medicare coverage.

PEIA needs information about Medicare coverage for you. Your premium decreases when you are retired and have Medicare.

Please provide the date when you were or will become eligible for Medicare. **When you become eligible for Medicare it is important that you enroll for both Medicare parts A and B**. Please see your summary plan description for more information.

PEIA needs information about your last employer prior to retirement and the last day worked (or will work) for that employer.

Dependent Information: Fill in any dependents that are to be covered under your health insurance plan. Please complete each box and if they are Medicare eligible, we will need a copy of their Medicare card. Please see the documentation chart in the Summary Plan Description to know what documentation is needed for proof of legal dependency for any dependents you may be adding.

Basic Life Beneficiary(s): PEIA no longer stores Beneficiary information.
Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are to continue your health care coverage into retirement, you must remain in the health care plan you were in as an active employee through the end of the plan year (June30), unless you were in a managed care plan and will be Medicare eligible when you retire. Please be sure to fully specify the plan you want, including the plan name and any option, such as PEIA PPB Plan A or the Health Plan Plan B. For life insurance, on this form you can continue your Basic Life insurance. If you wish to continue Optional and/or dependent coverage, you must complete the Retiree Optional Life Insurance form.

Earned Extended Benefits: If you have sick and/or annual leave credits, you must specify how you want to use those credits. You may use them to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. For details, please see your Summary Plan Description. If you were hired after July 1, 2001, you cannot use sick/annual leave credits to extend employer-paid insurance coverage.

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Affidavit: PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discount.

Acceptance: When you have made your selections on this form, you must sign and date the "Acceptance" box and sign and date the bottom of the acceptance box. If you do not wish to enroll for health or life insurance coverage as a retiree, you must mark the appropriate "Declination" box and sign and date below it.

What next: When your form is completed to this point, please return it to eh Benefit Coordinator at your place of employment. Your Benefit Coordinator in your HR department will complete the agency portion of the form and submit it for processing.

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Retiree Information

Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.) Social Security Number		
Mailing Address County of Residence		Medicare ID Number (HIC)
City State Zip		Home Telephone ( )
Physical Address		Sex (Circle one) M F
City State Zip		Date of Birth (mm/dd/yy)
Provide the date when you were or will be Medicare Eligible. Please also Provide a copy of your Medicare ID card now or when you are Medicare eligible.		
Provide the name of your last employer and your last day worked		

Dependent Information

Complete the following information **ONLY for dependents to be covered under your plan.**

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:

- ☐ Policyholder Only Health and Basic Life
  Print the name of the plan you choose here:_____
- ☐ Family Health and Basic Life
  Print the name of the plan you choose here:_____
- ☐ Basic Life Insurance Only (No Health Benefits)
- ☐ Basic Life Insurance Only (Health Benefits under spouse's PEIA plan)
- ☐ Health Insurance Only. (No Life Insurance Benefits) Print the name of the plan you choose here:_____

Earned Extended Benefits
Sick and/or Annual leave and Faculty Credits
I choose to use my credits to:

- ☐ Extend my employer-paid insurance coverage. Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining accrued leave.
- ☐ Increase my annuity amount. (Complete proper forms from CPRB)

Please be aware that if you submit conflicting documents regarding the use of your leave credits, the document you file with the CPRB will take precedence.

This form is continued on page 2. You must complete and return both pages of the form for it to be valid.

PLEASE Continue.

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Beneficiary(s

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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 or Basic Life Coverage. I decline to participate in **ANY** PEIA Coverage at this time.

Signature: Date:

Agency

Agency Name	Agency Account Number	Hire Date
Last date of active Employment	Effective Date of Retirement	Effective date of Retiree Insurance Coverage

Number of **Days** of accrued sick and annual leave for which the employee was not paid when employment ceased.

Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 moth family coverage)
Partial months are not allowed.

Total WV State Government credited years of service:

Higher Education Faculty Only: Total years of extended coverage in months:
3 and 1/3 years = 1 year of single coverage; 5 years' service = 1 year family coverage

Member Retirement from: ☐ TIAA-CREF ☐ TRS ☐ TDC ☐ PERS ☐ TROOPERS

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

Authorized Signature: Date: