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

OPT

Complete this form to enroll for or increase optional and/or dependent life insurance coverage. Complete all sections of the form except the one titled "AGENCY," which must be completed by the benefit coordinator at your place of employment. Return the completed form to your benefit coordinator. Do not mail it to PEIA.

EMPLOYEE

Name (Last) (First) (MI) (Generation)		Social Security Number
Gender (check one) ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Work Phone ( )
Street Address City State Zip Code		Home Phone ( )

Optional Life Insurance If you have enrolled in basic life insurance, you may choose to enroll for optional life and accidental death and dismemberment insurance for yourself. Your coverage is based on your selection and your age on the effective date of coverage. You must be actively at work on the day coverage becomes effective; otherwise coverage will be delayed until you are actively at work. Coverage of more than Plan X requires that you complete a Evidence of Insurability Form and be approved by the life insurance carrier. To enroll for coverage check the box beside the amount of optional life insurance you desire:

Employees Age	☐ Plan I	☐ Plan II	☐ Plan III	☐ Plan IV	☐ Plan V	☐ Plan VI	☐ Plan VII	☐ Plan VIII	☐ Plan IX
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 above	2,250	4,500	9,000	13,500	18,000	22,500	27,000	33,750	36,000

Employees Age	☐ Plan X	☐ Plan XI	☐ Plan XII	☐ Plan XIII	☐ Plan XIV	☐ Plan XV	☐ Plan XVI	☐ Plan XVII	☐ Plan XVIII
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 above	45,000	67,500	90,000	112,500	135,000	157,500	180,000	202,500	225,000

Please designate the beneficiary(s) of your optional life insurance coverage below. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J.A. Doe." You may change your beneficiary at any time by filing a Change-of-Beneficiary form with PEIA.

Beneficiary Name (Last, First, Middle Initial)	**Social Security Number**	**Relationship to the Insured**	**Address** (Street Address, City, State, Zip)

If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary, after his/her name above. lf no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries who 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.

Dependent Life Insurance - You may choose to enroll for dependent life and accidental death and dismemberment insurance 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 I $ 5,000 for your spouse and $ 2,000 for each child
☐ Plan II - $ 10,000 for your spouse and $ 4,000 for each child
☐ Plan III - $ 15,000 for your spouse and $ 7,000 for each child
☐ Plan IV - $ 20,000 for your spouse and $ 10,000 for each child

Dependent Name (Last, First, Middle Initial)	**Social Security Number**	**Date of Birth (mm/dd/yyyy)**	**Relationship**	**Date Eligible* (mm/dd/yyyy)**
			Wife Husband	
			Daughter Son	
			Daughter Son	
			Daughter Son	
			Daughter Son	
			Other specify below**	

* Date of Marriage or Adoption, if applicable. To add a dependent to your health coverage, you must complete a Change-In-Status form.
** Must be eligible dependent according to PEIA rules. See your PEIA Summary Plan Description for details. Specify relationship: _____

Selection, Acceptance, and Payroll Deduction Authority - I am enrolling for (Mark all that apply):

☐ Optional Life Insurance ☐ Dependent Life Insurance (spouse and/or child)

You must mark ONE of the following statements:

☐ The benefits have been explained to me, and I decline to participate.

☐ The benefits have been explained to me, and I hereby accept the forms of group coverage indicated above, and authorize deduction of my premium contribution from my earnings until revoked by me in writing. I understand that the PEIA may change the types or levels of benefits or the amount of contribution.

Employee's Signature: Date:

AFFIDAVIT

Tobacco Affidavit

Please mark which members of the family use tobacco and sign the acceptance box below. If the policyholder is tobacco-free, you will receive a discount on the optional life insurance premium. I acknowledge by signing the acceptance box below that WVPEIA 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 six (6) months

ACCEPTANCE

I hereby accept the basic life insurance. I understand that the PEIA may change the types 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 that those who provide false information may be prosecuted.

Employee Signature: Date:

AGENCY

To Be Completed By The Employer:

Agency Name		Account Number	
OPT Plan	Dep Plan	Date of Employment	Effective Date of Coverage

I hereby certify that the information above is true to the best of my knowledge, and that the employee is eligible for coverage under PEIA.

Authorized Signature: Date:

WHITE -- PEIA **PINK -- Payroll Location** **GOLD -- Employee**