State of West Virginia Public Employee Insurance Agency
Retiree 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"

RET OPT/DEP

Employee

Legal Name (Last) (First) (MI) (Generation: Jr., Sr., etc.)	Social Security Number
Mailing Address County of Residence	Home Telephone ( )
City State Zip	
Physical Address	Sex (Circle one) M F
City State Zip	Date of Birth (mm/dd/yy)

You Must be enrolled with BASIC LIFE to enroll in Optional and/or Dependent Life. If you have not enrolled for Basic Life, please fill out a Retiree Basic Life and Health Enrollment Form to enroll in Basic Life prior to submitting this form.

Optional Life

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
Under Age 65	$5,000	$10,000	$15,000	$20,000	$30,000
Age 65 to 69	3,250	6,500	9,750	13,000	19,500
Age 70 and above	2,500	5,000	7,500	10,000	15,000
Employee's Age	☐ Plan 6	☐ Plan 7	☐ Plan 8	☐ Plan 9	☐ Plan 10
Under Age 65	$40,000	*$50,000*	$75,000	$100, 000	$150,000
Age 65 to 69	26,000	*32,500*	48,750	65,000	97,500
Age 70 and above	20,000	*25,000*	37,500	50,000	75,000

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%

This form is continued. You must complete and return both pages of the form for it to be valid. Please Continue.

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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)	Date Eligible (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

Acceptance

I am enrolling in ☐ Optional Life ☐ Dependent Life

☐ The Benefits have been explained to me and I hereby decline to participate.

☐ 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.

Employee's Signature: Date:

Agency

Agency Name	Hire Date	Last Date of Active Employment
Account Number	Effective Date of Retirement	Effective Date of Retiree Coverage

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: