BASIC LIFE

State of West Virginia Public Employee Insurance Agency
Basic Life Enrollment Form

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

Employee

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

PEIA no longer stores Beneficiary information. Please visit mybenefits.metlife.com or call MetLife at 1-888-466-8640 for assistance.

Coverage

Decreasing Term Benefit For Active Employees for:

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

Affidavits

Tobacco Affidavit: Please mark which members of the family use tobacco and sign the form. If none of the people enrolled on your PEIA coverage use tobacco, you will receive the discount on your health and Opt/Dep life insurance premiums. I acknowledge by signing the acceptance box below that PEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: ☐ Policyholder

☐ Dependent (spouse and/or children) ☐ No Tobacco Users within the last (6) months

125

Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available?

☐ Yes ☐ No

Acceptance

☐ I hereby accept the Basic Life Insurance. I understand that PEIA may change the type or levels of benefits or the amount of contribution. I certify that the above information is true and correct and understand that providing false information on this form is illegal and those who provide false information may be prosecuted.

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

Employee's Signature: Date:

Agency

Agency Name	Account Number	Date of Employment
Jackson County Commission	802177709	

Hours worked Weekly	Effective Date of Coverage	Coverage Code	Index Code

I hereby certify that to the best of my knowledge, the information contained herein is accurate. I further certify the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employee Insurance Plan.

Authorized Signature : Date: