

**State of West Virginia Public Employee Insurance Agency
Change In Status Form**

CIS

Complete this form to Change the status of your coverage.
Complete all sections of the form except "AGENCY"

Employee	Full 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)

Change	Please indicate the status change you are making:	
	<input type="checkbox"/> Name Change: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (Last) _____ (First) _____ (MI) _____	
	<input type="checkbox"/> Add Dependents to: <input type="checkbox"/> Health <input type="checkbox"/> Dependent/Optional Life <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Complete Dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.	
	<input type="checkbox"/> Remove Dependents from: <input type="checkbox"/> Health <input type="checkbox"/> Dependent Optional Life: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5	
	<input type="checkbox"/> Change in Health Coverage from Plan _____ to Plan _____	
	<input type="checkbox"/> Add Health Coverage <input type="checkbox"/> PEIA Plan A <input type="checkbox"/> PEIA Plan B <input type="checkbox"/> PEIA Plan C <input type="checkbox"/> PEIA Plan D <input type="checkbox"/> The Health Plan HMO Plan A <input type="checkbox"/> The Health Plan HMO Plan B <input type="checkbox"/> The Health Plan PPO Plan C	
	<input type="checkbox"/> Drop Health Coverage. Keep Life Insurance Only. This terminates Health Coverage for Policyholder and all dependents.	
	<input type="checkbox"/> Tobacco Status Change	
	<input type="checkbox"/> Other, Please Specify _____	
	For each Qualifying event PEIA requires documentation. To add a dependent, PEIA requires documentation to substantiate legal dependency. Please see your Benefit Coordinator for questions about necessary documentation. The member's name, social security number and agency of employment must be written across the top of all documents submitted to PEIA.	
NOTE: If you have Mountaineer Flexible Benefits, you must update that plan separately by completing an FBMC enrollment form. Please visit https://peia.wv.gov/Forms-Downloads/Pages/Mountaineer-Flexible-Benefits.aspx for more information.		

Dependent Information	If spouse is currently insured by PEIA as a policyholder, please enter their Social Security Number _____						
	Legal Name (Last, First, MI, Generation)	Address (if different from above)	Relationship	Sex	Birth Date	Social Security Number	Other Health Insurance (Plan Name)

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Change in Status Reason	<input type="checkbox"/> Marriage	<input type="checkbox"/> Death of a dependent	<input type="checkbox"/> Open Enrollment
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth of a Child	<input type="checkbox"/> Affordable Care Act
	<input type="checkbox"/> Unpaid Leave of Absence by Employee, Spouse or Dependent	<input type="checkbox"/> Significant Change in Health Coverage	<input type="checkbox"/> Change from full-time to part-time or vice versa of the employee, spouse or dependent
	<input type="checkbox"/> Adoption	<input type="checkbox"/> Beginning or end of a dependent's employment	<input type="checkbox"/> Other (Please Specify):

COBRA	<p>Under federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by HealthSmart Solutions, who administers COBRA for PEIA. You will have a limited amount of time to elect continuation of coverage.</p> <p>COBRA premiums include both the employer and employee share of the premium, as well as an administrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact HealthSmart at 1-888-440-7342.</p> <p>If the dependent's address is different than the policyholder's address, please provide the dependent's mailing address below: Dependent Name: _____ Street Name: _____ City, State and Zip: _____</p>
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Affidavits	<p>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.</p> <p>Who uses tobacco: <input type="checkbox"/> Policyholder <input type="checkbox"/> Dependent (spouse and/or children) <input type="checkbox"/> No Tobacco Users within the last (6) months</p>
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Acceptance	<p><input type="checkbox"/> 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.</p> <p align="center">Employee's Signature: _____ Date: _____</p>
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Agency	Agency Name Jackson County Commission	Account Number 802177709
	Effective Date of Status Change	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: _____	