

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

BASIC LIFE ACA

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

Employee	Legal Name (Last) (First) (M I) (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)

If you need additional space than what is provided below, please use a blank sheet of paper and attach it to this form.

Beneficiary(ies)	Please delegate the beneficiary(ies) of this basic term life insurance policy in the space provided below. 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%

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:	
	<input type="checkbox"/> Dependent (spouse and/or children)	<input type="checkbox"/> Policyholder <input type="checkbox"/> No Tobacco Users within the last (6) months

Acceptance	<input type="checkbox"/> 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.	
	<input type="checkbox"/> 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
	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: _____	