State of West Virginia • Public Employees Insurance Agency
Change-In-Status Form

Change in Status

Complete this form to change the status of your coverage. Complete all sections as appropriate except the Employer Information on page 2 and return the form to your benefit coordinator.

Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Street Address Check if New Address ☐		County of Residence		Home Phone ( )
City	State	Zip	Job Title	Work Phone ( )

Do you participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES ☐ NO ☐

CHANGE TYPE Please indicate the status change you are making:

- 001 ☐ Change name listed above to: (Last)________ (First)________ (MI)____
- 002 ☐ Transfer employee's premium billing from employer account # ______ to account # ______ within the same agency
- 003 ☐ Add Dependents to: (Mark your choice) ☐ Health ☐ Dependent Optional Life Insurance (check one) ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4
  (Complete dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.)
- 004 ☐ Remove Dependents from: (Mark your choice and complete dependent information below) ☐ Health ☐ Dependent Optional Life Insurance
- 005 ☐ Change in health coverage: From: (Plan Name)________ To: (Plan Name)________
- 006 ☐ Add Health Coverage: ☐ PEIA PPB Plan A ☐ PEIA PPB Plan B ☐ PEIA PPB Plan C ☐ PEIA PPB Plan D ☐ Health Plan HMO Plan A ☐ Health Plan HMO Plan B
- 007 ☐ Drop Health Coverage. Keep life insurance ONLY. This terminates health coverage for policyholder and all dependents.
- 008 ☐ Tobacco Status Change.
- 009 ☐ Advance Directive/Living Will Affidavit Change.

Dependent Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)	Sex (Circle One)	Birth Date (mm/dd/yyyy)	Social Security Number
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		

Status Change Reason. Policyholder must provide documentation for every type of status change. See attached memo for details.

1 ☐	Marriage	5 ☐	Death of spouse or dependent	9 ☐	Change from full-time to part-time employment or vice versa for employee or spouse
2 ☐	Divorce	6 ☐	Beginning or end of spouse's employment	10 ☐	Open Enrollment
3 ☐	Birth of Child	7 ☐	Significant change in health coverage due to spouse's or dependent's employment	11 ☐	Other (please specify): ________
4 ☐	Adoption	8 ☐	Unpaid leave of absence by employee or spouse		

I certify that on ____/____/____(date of event) I incurred the status change marked above, and I, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the event. I further understand that I am required to provide documentation of this event to the WV Public Employees Insurance Agency.

This form is continued on page 2. You must complete and return both pages of the form for it to be valid. Please continue.

Change in Status Form
Page 2

Policyholder's Last Name: ______________________ Last four digits of SSN: __________

COBRA

Under Federal COBRA law, PEIA must offer continued coverage to qualified policyholders or dependents under certain circumstances. If you qualify, you will be sent notification with the necessary applications by HealthSmart Benefit Solutions, who administers COBRA for the PEIA. You will have a limited amount of time to elect continuation of coverage. If dependent's address is different than the policyholder's address, please provide the dependent's address here:

Dependent Name: ______________________

Street Address: ______________________

City, State, Zip ______________________

Premium Discount Affidavits

Tobacco Affidavit: Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your coverage uses tobacco, you will receive a premium discount on your health coverage and/or optional life insurance. 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

Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form in the Acceptance box below.

☐ By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.

Acceptance

I hereby accept the changes to my group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the changes I have made may affect my contributions. 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. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, of 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.

Employee's Signature: Date:

Employer Information -- TO BE COMPLETED BY AGENCY BENEFIT COORDINATOR

Account Number

☐☐☐☐☐☐☐☐☐

Agency Name (optional): ______________________

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 that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: Date:

Please submit only the original to PEIA