☐ I made changes online
(complete only what applies)
☐ Make changes for me

City of Charleston
PEIA Open Enrollment Change Form

Employee #:_____

Department: _____

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)

Open Enrollment Change(s)

Please indicate the change(s) you are making:

☐ Change in Health Coverage from Plan_____to Plan_____

☐ Add Health Coverage*: Plan _____

☐ Add Dependents to Health*

☐ Remove Dependents from Health

☐ Drop Health Coverage. Keep Life Insurance Only

☐ Tobacco Status Change

☐ Change in Dental/Vision from _____ Plan to _____ Plan

*PEIA requires documentation to add a dependent(s), PEIA requires documentation to substantiate legal dependency. To add a spouse PEIA will require a marriage license. To add a dependent child, PEIA will require a birth certificate.

Dependent Information

Legal Name(First Name, Last Name)	Social Security Number	Relationship	Sex	Birth Date	Medical (Y/N)	Dental/ Vision (Y/N)

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

Acceptance

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.

Employee Signature: Date:

Employee Name:	Employee #:	Department:

PEIA VOLUNTARY LIFE INSURANCE Separate from current Mutual of Omaha coverage

**An asterisk beside the plan number means Guaranteed Issue for New Hires within their initial enrollment period.

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**	☐ Plan 6**	☐ Plan 7**	☐ Plan 8**	☐ Plan 9**
Under Age 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000	*$60,000*	$75,000	$80, 000
Age 65 to 69	3,250	6,500	13,000	19,500	26,000	32,500	*39,000*	48,750	52,000
Age 70 and	2,250	4,500	9,000	13,500	18,000	22,500	*27,000*	33,750	36,000

Employee's Age	☐ Plan 10**	☐ Plan 11	☐ Plan 12	☐ Plan 13	☐ Plan 14	☐ Plan 15	☐ Plan 16	☐ Plan 17	☐ Plan 18
Under Age 65	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
Age 65 to 69	65,000	97,500	130,000	162,500	195,000	227,500	260,000	292,500	325,000
Age 70 and	45,000	67,5000	90,000	112,500	135,000	157,500	180,000	202,500	225,000

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%

PEIA DEPENDENT VOLUNTARY LIFE INSURANCE Separate from current Mutual of Omaha

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 $5,000 for your spouse $2,000 for each child	☐ Plan 2 $10,000 for your spouse $4,000 for each child	☐ Plan 3 $15,000 for your spouse $7,500 for each child	☐ Plan 4 $20,000 for your spouse $10,000 for each child	☐ Plan 5 $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)

Employee will automatically be the beneficiary on dependent life insurance coverage

Life Waiver

☐ 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.

☐ I do not wish to participate in PEIA OPT/Dep Life Insurance. I decline to participate in OPT/Dep Life Insurance.

Employee's Signature: Date:

*****Please make sure to sign above**

Health Care Spending Account Enrollment Form

Employee Information

Employee's Name (Last, First, Middle)	Social Security Number		Date of Birth
Employee's Address	City	State	ZIP
Phone Number	Department		Employee Number

Dependent Information

Spouse's Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth

Flexible Spending - FSA for all health plans except PPB plan C

$ [Annual Election Amount] ÷ 24 Paychecks = $ Amount Per Pay Period that will be deducted.

$240 minimum ($10) - $2750 Annual Maximum ($105.76)

[ ] I elect to participate. Please deduct $_____ per pay period for an annual total of $_____

Dependent Care

$5000 Annual Maximum, $2500 if married filing separate

[ ] I elect to participate. Please deduct $_____ per pay period for an annual total of $_____

Health Savings Account - HSA for PPB plan C only

Single cannot exceed $2200, family cannot exceed $4400

[ ] I elect to participate. Please deduct $_____ per pay period for an annual total of $_____

Authorization for Flexible Spending Account

Authorization: I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible qualifying event. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Any unused amounts remaining in my Health Care FSA account at the end of the plan year over the amount of$500.00 will be forfeited. Any unused amounts remaining in my Dependent Care FSA at the end of the plan year will be forfeited. However, I will have a specified period of time (90 days) after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or employment period.

Signature:_____Date: _____

HR Use Only
Effective Date:_____
Hire Date:_____
1st Payroll Deduction:_____