Department / EE#

City of Charleston Benefit Election Form

OFFICE USE	Hire Date:	THP Location	D/V Location	Tobacco	Effective Date

PERSONAL INFORMATION

First Name:		Last Name:		M. I.			
Mailing Add:		City:		State:		Zip:	
Physical Add (if different):		SSN:		County:			
Birth Date:		Phone #		Marital Status:		Gender	M ☐ F ☐

DEPENDENT INFORMATION

First Name	MI	Last Name	Relationship	Social Security	M/F	Date of Birth	Marriage Certificate	Birth Certificate

For more information on accessing the above documents, please visit http://www.wvdhhr.org/bph/hsc/vital/birthcert.asp.

Are you, your spouse, or any listed child covered by any other group health insurance? ☐ Yes ☐ No

If Yes: Spousal coverage may not be available. Please refer to Spousal Carve Out provisions. Does this Policy cover you? ☐ Yes ☐ No

Name of Policy Holder_____ Effective from:_____ Your Spouse? ☐ Yes ☐ No

Policy Number _____ Thru:_____ Your Children? ☐ Yes ☐ No

Insurance Company:_____ City & State: _____

FULL TIME

1. MEDICAL/ Rx

***PREMIUMS MAY CHANGE BASED ON TOBACCO USAGE**

Elections (24 pay periods):

Employee Only Coverage: ☐ PPB Plan A ($61.50 Per Pay Period) ☐ PPB Plan B (Please see Shoppers guide) ☐ PPB Plan C ($34.50 Per Pay Period)
☐ PPB Plan D (Please see Shoppers guide) ☐ HMO Plan A (Please see Shoppers guide) ☐ HMO Plan B (Please see Shoppers guide)
☐ **POS** (Please see Shoppers guide)

Employee/Children Coverage: ☐ PPB Plan A ($110 Per Pay Period) ☐ PPB Plan B (Please see Shoppers guide) ☐ PPB Plan C ($47 Per Pay Period)
☐ PPB Plan D(Please see Shoppers guide) ☐ HMO Plan A(Please see Shoppers guide) ☐ HMO Plan B (Please see Shoppers guide)
☐ **POS** (Please see Shoppers guide)

Family Coverage: ☐ PPB Plan A ($133 Per Pay Period) ☐ PPB Plan B (Please see Shoppers guide) ☐ PPB Plan C ($72 Per Pay Period)
☐ PPB Plan D (Please see Shoppers guide) ☐ HMO Plan A (Please see Shoppers guide) ☐ HMO Plan B (Please see Shoppers guide)
☐ **POS** (Please see Shoppers guide)

***Rates shown are for those that qualify for the tobacco free discount. There is $25 additional premium for single and $50 additional premium forfamily will be added for any employee and/or dependent who use tobacco products including includes vaping, Juuls, snuff, cigars, pipes, chewtobacco and cigarettes.**

☐ **Mark if you are a PEIA transfer - a separate form may need to be completed to transfer coverage**

☐ **WAIVE:** I certify that I have been given the opportunity to apply for medical benefits offered by CITY OF CHARLESTON, and that after careful consideration I have decided **NOT** to take advantage of this offer.

2. HSA Election (Plan C Only)

Complete this section ONLY if you elected PPB Plan C and would like to contribute additional pre-tax funds

If you have elected the PPB Plan C you may elect to have an annual election of up to **$4,150** (single) and **$**8,300 (family) deducted from your paycheck pretax* and deposited directly in your HSA. Please complete below if you are electing this option. Amount may be less if not participating for a full 12 months.

Single Coverage Election $_____ Per Paycheck that will be deducted.
(*remember to keep in mind the City's HSA contributions, maximum of $1,600. Contributions are prorated for start after July 1)

Family Coverage Election $_____ Per Paycheck that will be deducted
(*remember to keep in mind the City's HSA contributions, maximum of $3,200. Contributions are prorated for start after July 1)

I understand this election coverage is effective July 1, 2024 through June 30, 2025.

3. FSA Election (If you elect Plan C you cannot have an FSA)

Complete this section is you want to enroll in the FSA

FSA annual elections of up to $2850 can be deducted from your paycheck pretax and deposited directly in your FSA.

Please complete contact HR if you would like to enroll.

This election coverage is effective July 1, 2024 through June 30, 2025.

4. Dependent Care FSA (DCFSA)

The Dependent Care FSA maximum annual contribution is **$5,000** if you are single or if you are married and filing a joint income tax return; the limit is **$2,500 per parent** if you are married and filing a separate income tax return.

Please complete contact HR if you would like to enroll.

This election coverage is effective July 1, 2024 through June 30, 2025.

5. DENTAL/VISION BENEFITS Monthly Premiums

Dental / Vision Elections:

Standard: ☐ Single ($3.40) ☐ Family ($7.71)

Enhanced: ☐ Single ($6.75) ☐ Family ($16.08)

☐ **WAIVE:** I certify that I have been given the opportunity to apply for Dental/Vision benefits offered by CITY OF CHARLESTON, and that after careful consideration I have decided **NOT** to take advantage of this offer.

6. PEIA VOLUNTARY LIFE INSURANCE Separate from 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

7. PEIA DEPENDENT VOLUNTARY LIFE INSURANCE Separate from Mutual of Omaha coverage

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

8. TOBACCO AFFIDAVIT

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 uses tobacco, you will receive the discount on your health and 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

Certification:

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge. Any children under "Dependent Information" either reside with me in a parent-child relationship or are legally dependent on me for support. I understand that any amounts remaining in my Flexible Spending Account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment. I further give authorization to have all health, dental, vision, FSA, HSA, or DCFSA elections deducted on a pre-tax basis.

Signature: _____

Date:_____

MetLife

Group Term Life Insurance Beneficiary Designation

Metropolitan Life Insurance Company

Use this form to name the persons or entities you want to receive your life insurance proceeds after your death.

Things to know before you begin

- Completing this form replaces your existing beneficiary designations. Please provide details for **each** beneficiary, even if you have already given us this information in the past.
- Gather the name(s), date(s) of birth, Social Security/Tax ID number(s) and contact information for all of your beneficiaries.
- The beneficiaries you name on this form apply to your Group Term Life insurance coverage insured by MetLife.
- To name additional beneficiaries, attach a separate page. Provide the requested information including the beneficiary type *(primary or contingent)* and the % proceeds for each. Sign and date these page(s), making sure the date is the same as the date next to the signature on this form.
- Please complete and return all pages or we cannot record your choices.

Submit or update your beneficiary choices instantly at mybenefits.metlife.com

If you make a mistake anywhere on this form, cross it out and initial it.

SECTION 1: About the Insured

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Social Security number	Phone number

Address	City	State	ZIP

Employer name	Customer number
West Virginia Public Employees Insurance Agency (PEIA)	150596

SECTION 2: About the Plan

The beneficiaries you name on this form apply only to the MetLife-insured plan(s) selected below:

☐ All group term life coverage currently in effect

OR

☐ Basic Life/Personal Accidental Death & Dismemberment *(AD&D)*
☐ Supplemental/Optional Life
☐ Supplemental/Optional Accidental Death & Dismemberment *(AD&D)*

To name separate beneficiaries for the Life or AD&D coverages in this section, photocopy this form and complete a different form for each type of coverage.

SECTION 3: About the Primary Beneficiaries

These parties are your first choice to receive the insurance proceeds after your death. If a primary beneficiary dies before you, we will divide their share(s) equally between the remaining primary beneficiaries.

- You must name at least one (1) primary beneficiary.
- Please check the box and complete the form fields for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.
- Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers *(no fractions or decimals)* and make sure they *(and any listed on separate pages)* add up to 100%. To distribute them equally between your primary beneficiaries, leave **all** of the proceeds % fields blank.

About the Primary Beneficiaries *(continued)*

☐ **Individual**

First name	Middle name	Last name	**A**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Individual**

First name	Middle name	Last name	**B**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Individual**

First name	Middle name	Last name	**C**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Your Estate –** If you name your Estate as a primary beneficiary, you cannot name a contingent beneficiary. **D** Proceeds _____%

☐ **Testamentary Trust created in your Will –** The trust under your last Will and Testament as shall be admitted to probate. **E** Proceeds _____%

☐ **Living *(Inter Vivos)* Trust –** See further instructions on page 4. **F** Proceeds _____%

☐ **Charity/Organization –** List the charity or organization name and not an employee of the charity or organization. See further instructions on page 4. **G** Proceeds _____%

Total proceeds for all primary beneficiaries *(A-G plus any listed on separate pages)* must equal 100%. **100%**

SECTION 4: About the Contingent Beneficiaries

Skip this section if you're not naming a contingent beneficiary or if you named your Estate as a primary beneficiary.

Contingent beneficiaries receive the insurance proceeds **only** if all of the primary beneficiaries are deceased at the time of your death. If a contingent beneficiary dies before you, we will divide their share(s) equally between the remaining contingent beneficiaries.

- Please check the box and complete the form fields for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.
- Do not list the same person or entity as both a primary and a contingent beneficiary.
- Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers *(no fractions or decimals)* and make sure they *(and any listed on separate pages)* add up to 100%. To distribute them equally between your contingent beneficiaries, leave **all** of the proceeds % fields blank.

☐ **Individual**

First name	Middle name	Last name	**H**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐ M ☐ F	Social Security number / Phone number	Relationship to Insured	

☐ **Individual**

First name	Middle name	Last name	**I**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐ M ☐ F	Social Security number / Phone number	Relationship to Insured	

☐ **Your Estate** — **J** Proceeds _____%

☐ **Testamentary Trust created in your Will –** The trust under your last Will and Testament as shall be admitted to probate. — **K** Proceeds _____%

☐ **Living *(Inter Vivos)* Trust –** See further instructions on page 4. — **L** Proceeds _____%

☐ **Charity/Organization –** List the charity or organization name and not an employee of the charity or organization. See further instructions on page 4. — **M** Proceeds _____%

Total proceeds for all contingent beneficiaries *(H-M plus any listed on separate pages)* must equal 100%. — **100%**

SECTION 5: About your Trust/Charity/Organization Beneficiaries

Skip this section if you did not name a Living Trust or Charity/Organization as one of your beneficiaries. Otherwise, please provide the information requested below on a separate page. Make sure you include the type of beneficiary *(primary or contingent)* and that you sign and date these page(s).

Please include:

- Trust/Charity/Organization name
- Address
- Phone number
- Type of Beneficiary *(primary or contingent)*
- % of proceeds you are assigning to the Trust/Charity/Organization

Additional information required for Living *(Inter Vivos)* Trust(s):

- Trust date
- Trust Tax ID number
- Trustee first, middle and last name

SECTION 6: Signature required

By signing below, I hereby revoke any previous designations, and I designate the person, people, or entity named herein as beneficiaries.

☐ Check if you are completing and signing this form as agent for the insured under a valid Power of Attorney.
Please submit a copy of the Power of Attorney with this beneficiary form.

Please print and sign below

Insured/Owner first name	Middle name	Last name

Sign Here	Insured/Owner signature	**Date form completed *(mm/dd/yyyy)***

STOP

Did you remember to…

- ✓ Provide complete information for each of your beneficiaries?
- ✓ Make sure the total "proceeds %" for your **primary beneficiaries** *(including those on a separate page)* equals 100%? Separately, did you remember to make sure the total "proceeds %" for your **contingent beneficiaries** *(including those on a separate page)* equals 100%?
- ✓ Complete, sign and date any extra pages that list beneficiary information *(such as Living Trust/Charity/Organization beneficiaries)*?
- ✓ Cross out and initial any mistakes you made? *(If you crossed out any answers, your signature is not enough. You must also initial all your corrections.)*

  Example: ~~12/20/25~~ 12/20/15 *HM* ⇦ ***answer corrected, initials required***

Please note: we cannot record your beneficiary choices unless you complete these items.

SECTION 7: How to submit this form

Mail:
MetLife Recordkeeping & Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

Be sure to keep a copy of this completed form for your records.