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

City of Charleston
Open Enrollment/Qualifying Event 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: