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 Address (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 CHANGE BASED ON TOBACCO USAGE

Elections (24 pay periods):

Employee Only Coverage: ☐ PPB Gold ($80.00 Per Pay Period) ☐ PPB Silver (Please see Benefits Guide) ☐ PPB Gold High Ded ($58.00 Per Pay Period)
☐ PPB WV Bronze High Ded (Please see Benefits Guide) ☐ HMO Plan A (Please see Benefits Guide) ☐ HMO Plan B (Please see Benefits Guide)
☐ **POS** (Please see Benefits Guide)

Employee/Children Coverage: ☐ PPB Gold ($154.00 Per Pay Period) ☐ PPB Silver (Please see Benefits Guide) ☐ PPB Gold High Ded ($85.00 Per Pay Period)
☐ PPB WV Bronze High Ded (Please see Benefits Guide) ☐ HMO Plan A (Please see Benefits Guide) ☐ HMO Plan B (Please see Benefits Guide)
☐ **POS** (Please see Benefits Guide)

Family Coverage: ☐ PPB Gold ($190.00 Per Pay Period) ☐ PPB Silver (Please see Benefits Guide) ☐ PPB Gold High Ded ($120.00 Per Pay Period)
☐ PPB WV Bronze High Ded (Please see Benefits Guide) ☐ HMO Plan A (Please see Benefits Guide) ☐ HMO Plan B (Please see Benefits Guide)
☐ **POS** (Please see Benefits Guide)

***Rates shown do not include the tobacco free discount. There is a monthly $25 discount for single or $50 discount for family for tobacco free status. Tobacco products include vaping, Juuls, snuff, cigars, pipes, chewing tobacco 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

Complete this section ONLY if you elected PPB Gold High Deductible Plan **and would li**ke to contribute additional pre-tax funds

If you have elected the PPB Gold High Deductible Plan, you may elect to have an annual election of up to **$4,400** (single) and **$**8,750 (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 $2275. Contributions are prorated for start date after July 1)

Family Coverage Election $_____ Per Paycheck that will be deducted
(*remember to keep in mind the City's HSA contributions, maximum of $4550. Contributions are prorated for start date after July 1)

I understand this election coverage is effective July 1, 2026 through June 30, 2027.

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

FSA annual elections 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, 2026 through June 30, 2027.

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, 2026 through June 30, 2027.

5. DENTAL/VISION BENEFITS Monthly Premiums

Dental / Vision Elections:

Standard: ☐ Single ($5.21) ☐ Family ($11.64)

Enhanced: ☐ Single ($7.02) ☐ Family ($16.73)

☐ **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:_____