CHANGE IN STATUS FORMS

BIRTH OF CHIILD

Instructions for Birth of Child Packet

The following forms are included in this packet:

- Change in Status – Used to add the spouse to your health insurance.
- Delta Dental Enrollment Form
- MEMO

Change in Status Form:

Complete the demographic section

Complete the change type: Add Dependents to:

Fill in the name of the child in the boxes provided.

At the bottom of the form write in the date of the birth for the child

On the 2nd page complete the Premium Discount Affidavits.

Sign the Acceptance and Date

Delta Dental Enrollment Form

Complete the demographic section

Enter the information for your child

Sign and Date

MEMO

Write you name and the last four digits of your social security number and attach this to the copies of the birth certificate and the social security card you get before you send to PEIA.

You will need a copy of the certificate of live birth until you get the actual birth certificate. Send this and the completed forms to the Benefits Specialist.

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 [X] NO [ ]

CHANGE TYPE Please indicate the status change you are making:

001 [ ] Name Change: Policyholder ☐ Dependent ☐ (Last)_____ (First)_____ (MI)_____

002 [ ] Transfer employee's premium billing from employer account # _____ to account # _____ within the same agency

003 [X] Add Dependents to: (Mark your choice) [X] Health ☐ Dependent Optional Life Insurance (check one) ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5
(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 ☐ Health Plan PPO

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, spouse or dependent
2		Divorce	6		Beginning or end of spouse's or dependent's employment	10		Open Enrollment
3	X	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, spouse or dependent			

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

		8	0	0	3	9	0	0	5

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

Enrollment/Change Form

DELTA DENTAL DeltaVision®

Delta Dental of West Virginia and DeltaVision

One Delta Drive
Mechanicsburg, PA 17055
(800) 932-0783
TTY/TDD (888) 373-3582
www.deltadentalins.com

Please check the applicable box or boxes:

- ☐ New enrollment
- ☐ Coverage change
- ☐ Name change
- ☐ Retiree (0003)
- ☐ Address change
- ☒ Change of dependents
- ☐ Termination
- ☐ Decline coverage

Benefits Selection

Please check the applicable box or boxes.

- ☐ **Delta Dental PPO℠ plus Premier**
- ☐ **DeltaVision**

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female
Alternate Identification Number *(if applicable)*	Address Street	City		State	ZIP Code

Group Number (Check applicable box or boxes)

☐ 1094 (Dental) ☐ 8012 (Vision)

Sublocation

Dental _____
Vision _____

Group Name

Kanawha County School System

Change of Coverage

New Coverage: Former Coverage:

Name Change

From: To:

Dependent Change

Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Do you or your dependents have other DENTAL coverage?

☐ Yes ☐ No *If yes, please complete the following:* Carrier Name and Address: _____

Group Number: _____

Do you or your dependents have other VISION coverage?

☐ Yes ☐ No *If yes, please complete the following:* Carrier Name and Address: _____

Group Number: _____

First Name (if different)	First Name	MI	Last	Gender	Birth Date	Social Security Number
Spouse				M F		
Children				M F		
				M F		
				M F		
				M F		
				M F		

Date of Hire:

Primary Enrollee Signature: Date:

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Employer: _____ Date: _____ Coverage Effective Date: _____

E/C-D1105

Earl Ray Tomblin
Governor

Ted Cheatham
Director

WV Toll-free: 1-888-680-7342 • Phone: 1-304-558-7850 • Internet: www.wvpeia.com

To: PEIA Eligibility Documentation Unit

From: _____

Date: _____
(policyholder's name)

Re: Unique ID [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] number **OR**

Last four digits of SSN [redacted]-[redacted]-[ ][ ][ ][ ]

Please mark the type of transaction you're documenting and the documentation attached.

	Status Change Event	Documentation Required
	Divorce	Provide a copy of the divorce decree showing that the divorce is final.
	Marriage	Copy of valid marriage license or certificate
X	**Birth of Child**	Copy of child's birth certificate
	Adoption	Copy of adoption papers
	Adding coverage for a stepchild who resides with the policyholder	Copy of child's birth certificate.
	Adding coverage for any other child who resides with the policyholder	Court-ordered guardianship papers.
	Open Enrollment under spouse's employer's benefit plan	A copy of printed material showing open enrollment dates and the employer's name.
	Death of spouse or dependent	A copy of the death certificate.
	Beginning of spouse's employment	A letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered.
	End of spouse's employment	A letter from the spouse's employer stating the termination or retirement date, what coverage was lost, and dependents that were covered.
	Unpaid leave of absence by employee or spouse	A letter from your or your spouse's personnel office stating the date that you or your spouse went on unpaid leave or returned from unpaid leave.
	Significant Change in Health Coverage Attributable to Spouse's or Dependent's Employment	A letter from the spouse's insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered.
	Change from full-time to part-time employment or vice versa for employee or spouse	A letter from your or your spouse's employer stating the previous hours worked and the new hours worked and the effective date of the change.
I understand that PEIA cannot process my enrollment or change in enrollment for me or my dependents until these documents have been received.		

Please send this cover sheet with your documents to the address below.

601 57th Street, SE • Suite 2 • Charleston, WV 25304-2345
An equal opportunity employer.