FBMC™
Benefits Management

P.O.Box730561,OrmondBeach,FL32173-0561

RETIREE ENROLLMENT FORM

Plan Year 2012

July 1, 2011-June 30, 2012

STATE OF WEST VIRGINIA

Mountaineer Retiree Benefits

PLEASE PRINT USING A BALLPOINT PEN.

1

SOCIAL SECURITY #	EFFECTIVE DATE	Choose one: ☐ Pay by check (includes TIAA-CREF) ☐ Deduct from CPRB Retirement check

LAST NAME (RETIREE OR SURVIVING SPOUSE)	FIRST NAME (RETIREE OR SURVIVING SPOUSE)	MI

MAILING ADDRESS [STREET]

CITY	STATE	ZIP	BIRTH DATE	☐ MALE ☐ FEMALE

HOME PHONE	☐ MARRIED ☐ SINGLE ☐ WIDOW/WIDOWER	E-MAIL

INSTRUCTIONS

2 All retirees or surviving spouse must complete this application to enroll for coverage. Please complete the dependent information section if you select coverage that includes dependents. You do not need to complete the form if you wish to continue your current benefits without changes. However, if you choose to enroll or make changes, please mail the form to FBMC at P.O. Box 730 561, Ormond Beach, FL 32173-0561.

MOUNTAINEER RETIREE BENEFITS

3 Indicate all benefits selections by entering the necessary information below. Dependent eligibility is limited to the same benefit categories and amounts selected by the Retiree. If you elect dependent coverage for any benefit, you must provide dependent information in Section 4 below.

KEEP COVERAGE	CANCEL COVERAGE	ADD COVERAGE	BENEFITS		
☐	☐	☐	**DELTA DENTAL**	**CHOOSE ONE DENTAL OPTION:** ☐ Dental Assistance ☐ Basic ☐ Enhanced	**CHOOSE YOUR COVERAGE LEVEL:** ☐ Retiree Only ☐ Retiree & Spouse* ☐ Retiree & Children* ☐ Retiree & Family*

MONTHLY RETIREE DELTA DENTAL RATES

	Dental Assistance	Basic	Enhanced
Retiree Only	$10.46	$17.95	$29.85
Retiree & Children	$20.97	$35.95	$59.71
Retiree & Spouse	$23.39	$40.06	$69.33
Retiree & Family	$33.95	$58.10	$99.04

KEEP COVERAGE	CANCEL COVERAGE	ADD COVERAGE			
☐	☐	☐	**VISION**	**CHOOSE ONE VISION OPTION:** ☐ Full Service ☐ Exam Plus	**CHOOSE YOUR COVERAGE LEVEL:** ☐ Retiree Only ☐ Retiree & Family*

MONTHLY RETIREE VISION SERVICE PLAN RATES

	Full Service plan	Exam Plus plan
Retiree Only	$10.09	$1.69
Retiree & Family	$24.53	$3.84

*IF YOU SELECT DEPENDENT COVERAGE FOR ANY OF THE BENEFITS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.

4

DEPENDENT INFORMATION

DEPENDENT NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED	
				DENTAL	VISION
	SPOUSE				

I hereby authorize the WV Consolidated Public Retirement Board to deduct my insurance premiums from my monthly benefit check and make any subsequent premium changes as directed by FBMC. **Participants in the TIAA-CREF retirement plan**: I certify the preceeding benefit elections are correct and agree to remit payment to FBMC.

RETIREE SIGNATURE	DATE SIGNED

FBMC USE ONLY

EFFECTIVE DATE	CPRB	DIVISION

DATA ENTRY	VERIFICATION	SCANNED	INDEXED