

PLEASE PRINT USING A BALLPOINT PEN. PRESS FIRMLY; THE LAST COPY IS YOURS.

**1**

SOCIAL SECURITY #		E-MAIL		TYPE OF FORM <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> TRANSFER			
LAST NAME			FIRST NAME			MI	
HOME ADDRESS (STREET)			CITY		STATE	ZIP	HOME PHONE
BIRTH DATE / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	DATE EMPLOYED / /		BENEFIT START DATE		OFFICE PHONE

### INSTRUCTIONS

**2**

**WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?**

- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage of other benefits
- Employees who wish to participate in the myFBMC Card<sup>SM</sup> Visa<sup>®</sup> Card program for the first time or current participants who wish to cancel.
- **EXISTING BENEFITS NOT INDICATED ON THIS FORM WILL CONTINUE AS CURRENTLY ENROLLED.**

**HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:**

- **IMPORTANT:** If you want to add, change or cancel coverage, **you must check the box beside the appropriate benefit** in Section 3. Indicate coverage levels and any other pertinent information.
- If you select family coverage for any benefit, you must provide dependent information in Section 4.

**RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN APRIL 30, 2009.**

## Mountaineer Flexible Benefits

Tax-Free Benefits Paid by Employees

**3**

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS		COST PER PAY PERIOD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DELTA DENTAL</b> <input type="checkbox"/> Dental Assistance <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse* <input type="checkbox"/> Employee & Children* <input type="checkbox"/> Employee & Family*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VISION CHOOSE ONE VISION OPTION:</b> <input type="checkbox"/> Full Service <input type="checkbox"/> Exam Plus	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LONG-TERM DISABILITY INCOME PLAN Employee Only</b> (If you enroll in this benefit, please be sure to provide your birthdate and salary in the space provided above in Section 1.)	<input type="checkbox"/> 60% of salary coverage <input type="checkbox"/> 40% of salary coverage	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SHORT-TERM DISABILITY INCOME PLAN Employee Only</b> (If you enroll in this benefit, please be sure to provide your birthdate and salary in the space provided above in Section 1.)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT</b> Use cost per-pay-period from your Worksheet. ALL CLAIMS MUST BE SUBMITTED BY October 31, 2010.	<input type="checkbox"/> I elect to receive the myFBMC Card <sup>SM</sup> Visa <sup>®</sup> Card.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b> <input type="checkbox"/> Married, filing separately <input type="checkbox"/> Married, filing jointly <input type="checkbox"/> Single, head of household	Use cost per-pay-period from your Worksheet. ALL CLAIMS MUST BE SUBMITTED BY October 31, 2010.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LEGAL (Post-tax)</b>		
<b>TOTAL PER-PAY-PERIOD FSA ADMINISTRATIVE FEE</b>						
<b>TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD</b>						

\*IF YOU SELECT DEPENDENT COVERAGE FOR DENTAL, VISION OR LEGAL, YOU MUST COMPLETE THE INFORMATION BELOW.

**4**

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

**FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)**

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FRINGE BENEFITS MANAGEMENT COMPANY, THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

**TURN COMPLETED FORM INTO YOUR BENEFITS COORDINATOR NO LATER THAN APRIL 30, 2009.**

FEIN# _____
AGENCY# & NAME _____
EFFECTIVE DATE _____
NO. PAY DEDUCTIONS _____
GROSS ANNUAL SALARY _____
BENEFIT COORDINATOR SIGNATURE _____
BENEFIT COORDINATOR PHONE# (    ) _____
BENEFIT COORDINATOR FAX# (    ) _____
LOCATION TYPE <input type="checkbox"/> WVU <input type="checkbox"/> STATE AGENCIES, COLLEGES & UNIV SCHOOLS <input type="checkbox"/> COUNTY BOARDS OF EDUCATION/ <input type="checkbox"/> OTHER
APPLICATIONS SHOULD BE MAILED TO FBMC TWICE EACH WEEK DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY MAY 7, 2009.

EMPLOYEE SIGNATURE _____	DATE SIGNED _____	TIME SIGNED _____
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**FBMC USE ONLY**

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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