Washington State Health Care Authority
Public Employees Benefits Board

Clear All Fields

2016 Leave Without Pay (LWOP) Election/Change

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** after the date your employer-sponsored coverage ends or from the postmark on the *PEBB Continuation of Coverage Election Notice* packet sent to you, whichever is later.
- **We must receive your first payment before we can enroll you.** Premiums and applicable surcharges are due back to when your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all *Leave Without Pay (LWOP) Continuation Coverage Election/Change* forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form.

All forms and documents are available at **www.hca.wa.gov/pebb** or by calling 1-800-200-1004.

Qualifying Event for Leave Without Pay Coverage *Check only one.*

- ❑ Applying for disability retirement
- ❑ Layoff
- ❑ USERRA (military) leave
  Date called to duty in the uniformed services _____
- ❑ Reversion employee
- ❑ Approved leave without pay (LWOP)
- ❑ Workers' compensation
- ❑ Approved educational leave
- ❑ Faculty between periods of eligibility
- ❑ Seasonal employee off-season
- ❑ Employee appealing a dismissal action

Section 1: Subscriber Information

Date employer coverage ended

Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address / Apt./unit number	City	State	ZIP Code
Mailing address (if different from above) / Apt./unit number	**City**	**State**	**ZIP Code**

County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number ( )	Home phone number ( )

❑ **Continue coverage:** *(select all that apply)*
❑ Medical and dental ❑ Medical only ❑ Dental only ❑ Life insurance
❑ Long-term disability insurance (only if on educational or military leave)

If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions.

❑ **Cancel coverage:**
❑ Medical and dental ❑ Medical only ❑ Dental only ❑ Life insurance
❑ Long-term disability insurance (only if on educational or military leave)

Reason_____ Cancel date_____

I understand that I am forfeiting all further rights to enroll in PEBB benefits cancelled above unless I regain eligibility.

(continued)

2016 Leave Without Pay (LWOP) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 1: Subscriber Information *(continued)*

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you or a family member (age 13 or older) enrolled on your PEBB medical coverage uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. See the 2016 Premium Surcharge Help Sheet at **www.hca.wa.gov/pebb** *for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.*

Does the tobacco use premium surcharge apply to you? Check one:

❑ YES, I have used tobacco products in the past two months.

❑ NO, or I have used the tobacco cessation resources noted in the *2016 Premium Surcharge Help Sheet*.

Section 2: Spouse or Registered Domestic Partner Information

List an eligible spouse or registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If adding a registered domestic partner you must provide proof of eligibility within PEBB's enrollment timelines, or the registered domestic partner will not be enrolled.*** *A list of documents we will accept to verify eligibility is available at* **www.hca.wa.gov/pebb**.

Relationship to subscriber

❑ Spouse: date of marriage _____ ❑ Registered domestic partner: date registered _____

Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code	Date of birth (mm/dd/yyyy)

❑ **Continue coverage:** *(select all that apply)* ❑ Medical and dental ❑ Medical only ❑ Dental only ❑ Life insurance

❑ **Add coverage:** *(select all that apply)* ❑ Medical and dental ❑ Medical only ❑ Dental only ❑ Life insurance

❑ **Cancel coverage:** *(select all that apply)* ❑ Medical and dental ❑ Medical only ❑ Dental only ❑ Life insurance

Reason _____ Cancel date _____

If removing a spouse or registered domestic partner due to divorce or dissolution of domestic partnership, attach a copy of the divorce decree or dissolution of registered domestic partnership.

Does the tobacco use premium surcharge apply to your spouse or registered domestic partner?

Read each option and check only one:

❑ I previously attested to my spouse's or registered domestic partner's tobacco use and my attestation has not changed.

❑ YES, my spouse or registered domestic partner has used tobacco products in the past two months.

❑ NO, or my spouse or registered domestic partner has used the tobacco cessation resources noted in the *2016 Premium Surcharge Help Sheet*.

Spouse or Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if your spouse or registered domestic partner has elected not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2016 Premium Surcharge Help Sheet *and the* 2016 Spousal Plan Calculator *at* **www.hca.wa.gov/pebb**. *To change your attestation, use the* 2016 Premium Surcharge Change Form. *If you check YES below or leave this section blank, you will pay the monthly surcharge.*

Does the spouse or registered domestic partner coverage surcharge apply to you? Check one:

❑ YES, I used the *2016 Premium Surcharge Help Sheet* and completed the *2016 Spousal Plan Calculator* online.

❑ NO, I used the *2016 Premium Surcharge Help Sheet* and, if needed, completed the *2016 Spousal Plan Calculator* online.

Which questions, if any, on the *2016 Premium Surcharge Help Sheet* did you check NO? Check all that apply.

❑ Question 1 ❑ Question 2 ❑ Question 3 ❑ Question 4 ❑ Question 5 ❑ Question 6

❑ PEBB Program to determine. I am completing and submitting the printed *2016 Spousal Plan Calculator* from **www.hca.wa.gov/pebb**.

(continued)

2016 Leave Without Pay (LWOP) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 3: Family Member Information (such as child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. Attach a completed Extended Dependent Certification *form if enrolling an extended dependent. If enrolling a dependent with a disability age 26 or older, submit a completed* Certification of Dependent with a Disability *form and return as instructed on the form.*

A	**Relationship to subscriber**	*Check only if age 26 or older.* Disabled? ❑ Yes ❑ No	Sex ❑ M ❑ F	Social Security number

Extended dependent validated by court order? ❑ Yes ❑ No

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select all that apply)*	❑ Medical and dental	❑ Medical only	❑ Dental only	❑ Life insurance
❑ **Add coverage:** *(select all that apply)*	❑ Medical and dental	❑ Medical only	❑ Dental only	❑ Life insurance
❑ **Cancel coverage:** *(select all that apply)*	❑ Medical and dental	❑ Medical only	❑ Dental only	❑ Life insurance

Reason _____ Cancel date _____

Does the tobacco use premium surcharge apply to this family member?
(Response required for family members ages 13 or older.) Check only one:
❑ YES, this family member has used tobacco products in the past two months.
❑ NO, or this family member has used the tobacco cessation resources noted in the *2016 Premium Surcharge Help Sheet*.

B	**Relationship to subscriber**	*Check only if age 26 or older.* Disabled? ❑ Yes ❑ No	Sex ❑ M ❑ F	Social Security number

Extended dependent validated by court order? ❑ Yes ❑ No

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select all that apply)*	❑ Medical and dental	❑ Medical only	❑ Dental only	❑ Life insurance
❑ **Add coverage:** *(select all that apply)*	❑ Medical and dental	❑ Medical only	❑ Dental only	❑ Life insurance
❑ **Cancel coverage:** *(select all that apply)*	❑ Medical and dental	❑ Medical only	❑ Dental only	❑ Life insurance

Reason _____ Cancel date _____

Does the tobacco use premium surcharge apply to this family member?
(Response required for family members ages 13 or older.) Check one:
❑ YES, this family member has used tobacco products in the past two months.
❑ NO, or this family member has used the tobacco cessation resources noted in the *2016 Premium Surcharge Help Sheet*.

Section 4: Changes to an Existing Account

Are you making changes to an existing account?

❑ **Yes** **If yes, what changes?** *(Check all that apply in the sections below.)* ❑ **No** *If no, go to Section 5.*

Changes you can make anytime

Give date of event/change _____

❑ Name change ❑ Address change ❑ Cancel medical coverage ❑ Cancel dental coverage ❑ Cancel life insurance

❑ Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of registered domestic partnership, death, or other loss of eligibility under PEBB rules), **we must receive this form no later than 60 days after the last day of the month the dependent loses eligibility for health plan coverage.** Coverage will be cancelled the last day of the month of loss of eligibility. If applicable, provide former dependent's new address:

_____

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested. ❑ Add dependent(s) ❑ Change medical plan ❑ Change dental plan

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 4: Changes to an Existing Account *(continued)*

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. **The PEBB Program must receive this form and proof of the event no later than 60 days after the event.** However, if adding a newborn or adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.

Check the box next to each change you are requesting, and indicate the corresponding event(s) below. See the numbers beside each change to verify that your requested change may be allowed. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

- ❑ **Add dependent(s)** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10, 11)
- ❑ **Change medical plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14)
- ❑ **Change dental plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14)

  Give date of event _____

Check the box(es) next to the corresponding event(s). The event number below must be listed next to the change(s) you are requesting above.

- ❑ 1. Marriage, registering a domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ❑ 2. Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form available at **www.hca.wa.gov/pebb**.
- ❑ 3. Child becoming eligible as a dependent with a disability. Also complete a *Certification of Dependent With a Disability* form available at **www.hca.wa.gov/pebb**.
- ❑ 4. Subscriber or dependent losing other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ❑ 5. Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for their employer contribution toward employer-based group health insurance.
- ❑ 6. Subscriber or dependent having a change in enrollment under another employer-based group health insurance during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ❑ 7. Subscriber's dependent moving from outside the United States to live within the United States or moving from inside the United States to live outside the United States.
- ❑ 8. Subscriber or dependent having a change in residence that affects health plan availability.
- ❑ 9. A court order or National Medical Support Notice requiring the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.
- ❑ 10. Subscriber or dependent becoming entitled to or losing eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ 11. Subscriber or dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- ❑ 12. Subscriber or dependent becoming entitled to or losing eligibility for Medicare, or enrolling in or cancelling enrollment in a Medicare Part D plan.
- ❑ 13. Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).
- ❑ 14. Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

Are you or any eligible dependents enrolled in PEBB coverage under another account? ❑ Yes ❑ No

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 5: Medical Plan Selection *Check only one.*

Contact the plans for benefits information; their contact information is located at the end of this form.

Group Health Cooperative
- ❑ Group Health Classic
- ❑ Group Health SoundChoice
- ❑ Group Health Value

Group Health Options Inc.
- ❑ Group Health Consumer-Directed Health Plan

Kaiser Foundation Health Plan of the Northwest
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan
- ❑ UMP Plus-Puget Sound High Value Network
- ❑ UMP Plus-UW Medicine Accountable Care Network

Section 6: Dental Plan Selection *Check only one.*

Before you select a dental plan, be sure your provider(s) participate with that plan.

Preferred Provider Organization
You can choose any dental provider and change providers at anytime.

- ❑ Uniform Dental Plan, administered by Delta Dental of Washington (Group #3000)

Managed-Care Plans
You must choose a provider from the dental plan network. Before you select a managed-care plan, be sure to call the dental plan to verify your provider is in their network and fill in the requested information below.

- ❑ DeltaCare, administered by Delta Dental of Washington (Group #3100)
  Call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.

  Dentist name or clinic code _____

- ❑ Willamette Dental of Washington, Inc.
  Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

  Clinic location _____

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 7: Life and Accidental Death & Dismemberment (AD&D) Insurance

Current Enrollment With Agency	Coverage Amount
❑ Basic Employee Life and AD&D ($3.89/month guaranteed through December 31, 2016)	$ 25,000 Life / $ 5,000 AD&D
❑ Supplemental Employee Life (subscriber must continue Basic Employee Life to continue Supplemental Employee Life)	$ _____
❑ Basic Spouse or Registered Domestic Partner Life (subscriber must continue Basic Employee Life to continue Basic Spouse or Registered Domestic Partner Life)	$ 2,500
❑ Basic Children Life (subscriber must continue Basic Employee Life to continue Basic Children Life)	$ 2,500 per child
❑ Supplemental Spouse or Registered Domestic Partner Life (subscriber must continue Basic Employee and Supplemental Employee Life Insurance, and spouse or registered domestic partner must continue Basic Spouse or Registered Domestic Partner Life to continue Supplemental Spouse or Registered Domestic Partner Life)	$ _____
❑ Supplemental Employee AD&D (Supplemental Employee AD&D cannot be continued if the employee is on active military duty)	$ _____

❑ Include Supplemental AD&D for dependents
❑ **Do not** include Supplemental AD&D for dependents

Section 8: Life and Accidental Death & Dismemberment (AD&D) Insurance *(continued)*

Desired Enrollment While Self-Paying

❑ I wish to maintain the same coverage I had as an active employee. _____ *(initials)*

❑ I wish to maintain the same Basic Life Insurance (employee, spouse or registered domestic partner, and/or children) I had as an active employee, and reduce the amount of Supplemental Life Insurance (employee, or employee and spouse or registered domestic partner). **I understand that I must reapply for Supplemental Life Insurance and submit evidence of insurability to the carrier for approval when I return to work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work.** _____ *(initials)*

❑ I do not wish to continue life coverage while eligible for self-pay. **I understand that I must reapply for Supplemental Life Insurance and submit evidence of insurability to the carrier for approval when I return to work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work.** _____ *(initials)*

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 9: Long-Term Disability

This section applies **only** to employees on approved educational leave or called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Current Enrollment With Agency

❑ **Basic coverage** ($2.10/month)

❑ **Optional coverage** *(select a waiting period)*

❑ 30-Day ❑ 90-Day ❑ 180-Day ❑ 300-Day

❑ 60-Day ❑ 120-Day ❑ 240-Day ❑ 360-Day

Desired Enrollment While Self-Paying

❑ I wish to maintain the same coverage I had as an active employee. _____ *(initials)*

❑ I wish to maintain the same Basic Long-Term Disability Insurance I had as an active employee, and increase the Optional Long-Term Disability Insurance waiting period. **I understand that I must reapply for the lower waiting period under Optional Long-Term Disability and submit evidence of insurability to the carrier for approval when I return to work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work.** _____ *(initials)*

❑ I do not wish to maintain the long-term disability coverage I had as an active employee. **I understand that I must reapply for the lower waiting period under Optional Long-Term Disability and submit evidence of insurability to the carrier for approval when I return from work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work.** _____ *(initials)*

(continued)

2016 Leave Without Pay (LWOP) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 10: Signature *Required*

I have received and read the *PEBB Continuation of Coverage Election Notice,* including any appendices. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of PEBB insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or registered domestic partner coverage premium surcharge in addition to my monthly premium.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

This form replaces all *Leave Without Pay (LWOP) Continuation Coverage Election/Change* forms I have previously submitted to the PEBB Program.

HCA's Privacy Notice:

We will keep your information private as allowed by law. To see our Privacy Notice, go to **www.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

Please sign and date this form.

Mail to:	**If payment is enclosed, make it payable to Health Care Authority and mail to:**	**Or hand-deliver to:**
Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684	Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695	Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

2016 PEBB Medical Contractors

Group Health Cooperative
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc.
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 711

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Ave., Suite 235, Seattle, WA 98101
1-888-849-3681 or TTY 711

2016 PEBB Life Insurance Contractor

ReliaStar Life Insurance Company
20 Washington Ave. S., Route 4-N, Minneapolis, MN 55440-002
(Policy Form #LP00GP) **1-866-689-6990**

2016 PEBB Dental Contractors

DeltaCare, administered by Delta Dental of Washington
9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan
administered by Delta Dental of Washington
9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)

2016 PEBB Long-Term Disability Insurance Contractor

Standard Insurance Company
411 108th Ave. NE, Suite 400, Bellevue, WA 98004
1-800-368-2860