Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Premium Payment Plan Election/Change Form

- Type or print clearly in dark ink.
- Your personnel, payroll, or benefits office completes Section 1.
- You complete Section 2, and **either** Section 3 or Section 4.
- You may use this form:
  - When you are newly eligible for PEBB benefits and wish to opt out of the premium payment plan (complete Section 3).
  - During the PEBB Program's annual open enrollment.
  - After an event that creates a special open enrollment (for example, a change in employment status, marriage, birth, adoption, etc.). The change must correspond to and be consistent with the event that creates the special open enrollment. For more information about changes you can make during a special open enrollment, read Policy 45-2A at **www.hca.wa.gov/employee-retiree-benefits/rules-and-policies**.

Section 1: Agency Information *Personnel, payroll, or benefits office completes this section.*

Agency/sub agency	Effective date (mm/dd/yyyy)	Employee's hire date

Section 2: Subscriber Information *Employee completes this section.*

Social Security number	Name (last, first, middle initial)		Is this a name change? ☐ Yes ☐ No	
Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different)	Apt./unit number	City	State	ZIP Code
County	Home phone number ( )	Work phone number ( )	Date of birth (mm/dd/yyyy)	

Section 3: Opt Out of Participation in the Premium Payment Plan

Employee completes this section or Section 4, but not both.

I elect to opt out of participation in the state of Washington's Premium Payment Plan. I understand that any premium for my PEBB medical coverage, and any applicable premium surcharges, will be deducted from my paycheck **after** federal and/or state taxes have been collected. I understand that I cannot enroll in a Medical Flexible Spending Arrangement, Dependent Care Assistance Program, or a consumer-directed health plan with a health savings account.

Employee's signature ____________________ Date ____________

Section 4: Enroll in Premium Payment Plan

Employee completes this section or Section 3, but not both.

I elect to enroll in the state of Washington's Premium Payment Plan. I understand that by participating in the Premium Payment Plan, any premium I am required to pay for the selected medical coverage, and any applicable premium surcharges, will be deducted from my paycheck **before** federal and/or state taxes have been collected.

Employee's signature ____________________ Date ____________

Return original to your personnel, payroll, or benefits office. Keep a copy for your records.