Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Clear Form

# 2018 Employee Enrollment/Change

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **List eligible family members you wish to cover or remove from coverage. This form replaces all *Employee Enrollment/ Change* forms previously submitted.**

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

## 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 1.)*

## Changes you can make anytime

❑ Name change ❑ Address change *Give date of event/change* _____

❑ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB benefits). **Your personnel, payroll, or benefits office must receive this form no later than 60 days after the event.** If applicable, provide former dependent's new address:

_____

## Changes you can make during the PEBB Program's annual open enrollment (November 1-30)

*All changes become effective January 1 of the following year.*

**Check the box(es) next to the change requested.**

❑ Add dependent(s)
❑ Remove dependent(s)
❑ Change medical plan
❑ Change dental plan
❑ Enroll after waiving medical coverage
❑ Waive medical due to enrollment in other employer-based group medical, TRICARE, or Medicare.

## 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 change must be allowable under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with a special open enrollment event for the employee, employee's dependent, or both. You are required to provide proof of the event. **Your personnel, payroll, or benefits office must receive this form and proof of the event no later than 60 days after the event.** However, if adding a newborn or newly adopted child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

**Check the box next to the change you are requesting and the corresponding event on the following page.**
In most cases, the enrollment or change will be effective the first day of the month after the event date or the date this form is received, whichever is later.

❑ **Add dependent(s)**
❑ **Enroll after waiving medical coverage**
❑ **Change medical plan**
❑ **Change dental plan**
❑ **Remove dependent(s)**
❑ **Waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare**

*(this section continued on next page)*

| **This section to be completed by employer.** | | | |
|---|---|---|---|
| Agency name | Agency/subagency | Insurance effective date | Hire date |
| | | | |

## 2018 Employee Enrollment/Change

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

**The following events allow an employee to add dependent(s), enroll after waving medical, remove dependent(s), change medical and/or dental plans, and waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare.**

- ❑ Marriage, registering a domestic partner, as defined by Washington Administrative Code 182-12-260(2), birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. Also complete a *Declaration of Tax Status* form if adding a non-qualified tax dependent.
- ❑ Employee has a change in employment status that affects the employee's eligibility for his or her employer contribution toward his or her employer-based group health plan.
- ❑ Employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.
- ❑ Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).

**The following events allow an employee to add dependent(s), enroll after waiving medical, and change medical and/or dental plans.**

- ❑ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form.
- ❑ Employee or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act.
- ❑ Employee or dependent becomes eligible for a state premium assistance subsidy for PEBB health coverage from Medicaid or a state CHIP.

**The following events allow an employee to add dependent(s), enroll after waving medical, remove dependent(s), and waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare.**

- ❑ Employee or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ❑ Employee's dependent moves from outside the United States to live within the United States or moves from inside the United States to live outside the United States.

**The following events allow an employee to add dependent(s), enroll after waiving medical, remove dependent(s) and change medical and/or dental plans.**

- ❑ A court order or National Medical Support Notice requires the employee or any other individual to provide a health plan for an eligible child of the employee.

**The following events allow an employee to change medical and/or dental plans.**

- ❑ Employee or dependent has a change in residence that affects health plan availability.
- ❑ Employee or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ❑ Employee's or dependent's current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account.
- ❑ Employee or dependent experiences a disruption of care that could function as a reduction in benefits for the employee or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

**The following events allow an employee to enroll after waiving medical, and waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare.**

- ❑ Employee or dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE.
- ❑ Employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

## Section 1: Subscriber Information

| 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) | Work phone number ( ) | Home phone number ( ) |
|---|---|---|---|
| | | | |

**Are you or any eligible dependents already enrolled in PEBB insurance coverage under another account?** ❑ **Yes** ❑ **No**
If yes, please contact your personnel, payroll, or benefits office for assistance.

**Medical coverage** ❑ Cover ❑ Waive: effective date _____

*If waiving, see Section 6.* **Note:** If you waive coverage, you must be enrolled in other employer-based group medical, TRICARE, or Medicare. You cannot enroll your eligible dependents in medical.

**Dental coverage** ☒ Cover (Dental may not be waived.)

**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 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. If you check YES or leave the check boxes blank, you will pay the monthly $25 premium surcharge. See the *2018 Premium Surcharge Help Sheet* available at **www.hca.wa.gov/pebb** for instructions on how to respond.

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

❑ **YES, I am subject to the $25 premium surcharge.** I have used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date your tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** I have not used tobacco products in the past two months, or I have used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

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

## Section 2: Spouse or State-Registered Domestic Partner Information

- Skip this section if you are not enrolling a spouse or state-registered domestic partner.
- List an eligible spouse or state-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 spouse or state-registered domestic partner, you must provide proof of eligibility within the PEBB Program's enrollment timelines or the spouse or state-registered domestic partner will not be enrolled.
- Forms and a list of documents we will accept to verify eligibility are available at **www.hca.wa.gov/pebb.**

**Relationship to subscriber**
(If adding a non-qualified tax dependent, please attach a completed *Declaration of Tax Status* form.)

❑ Spouse: date of marriage _____

❑ State-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) | |
|---|---|
| | |

**Medical coverage** ❑ Cover
❑ Remove from medical Reason _____

**Dental coverage** ❑ Cover
❑ Remove from dental Reason _____

**Tobacco Use Premium Surcharge**

**Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner?** Check one:

❑ **YES, I am subject to the $25 premium surcharge.** My spouse or state-registered domestic partner has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** My spouse or state-registered domestic partner has not used tobacco products in the past two months, or he or she has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

**Spouse or State-Registered Domestic Partner Coverage Premium Surcharge**
The PEBB Program requires a monthly $50 surcharge in addition to your premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and your spouse or state-registered domestic partner has elected not to enroll in employer-based group medical that is comparable to Uniform Medical Plan Classic. See the *2018 Premium Surcharge Help Sheet* for instructions on how to respond. If you check YES below or leave this section blank, you will pay the monthly premium surcharge.

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

❑ **YES, I am subject to the $50 premium surcharge.** I used the *2018 Premium Surcharge Help Sheet* and completed the *2018 Spousal Plan Calculator* online.

❑ **NO, I am not subject to the $50 premium surcharge.** I used the *2018 Premium Surcharge Help Sheet* and, if needed, completed the *2018 Spousal Plan Calculator* online.

**Which questions, if any, on the *2018 Premium Surcharge Help Sheet* did you check NO? Check all that apply.**
Question 1 is not applicable. ❑ Question 2 ❑ Question 3 ❑ Question 4 ❑ Question 5 ❑ Question 6

❑ **Employer to determine if premium surcharge applies.** I used the *2018 Premium Surcharge Help Sheet* and am completing and submitting a printed *2018 Spousal Plan Calculator*. My employer will determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to UMP Classic.

The *2018 Premium Surcharge Help Sheet* and the *2018 Spousal Calculator* are available at **www.hca.wa.gov/pebb**. To change your attestation, use the *2018 Premium Surcharge Change Form.*



*(continued)*

| Subscriber's last name | First name | Middle initial | Social Security number |
|---|---|---|---|
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## Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

- Skip this section if you are not enrolling additional family 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.
- If adding a family member, you must provide proof of eligibility for each family member within the PEBB Program's enrollment timelines or the family member will not be enrolled. If adding a non-qualified tax dependent, also attach a *Declaration of Tax Status form*.
- If enrolling an extended dependent attach an *Extended Dependent Certification* form.
- If enrolling a dependent with a disability age 26 or older, submit a completed *Certification of Dependent With a Disability* form as instructed on the form. Refer to the *2018 Employee Enrollment Guide* for eligibility information.
- Forms and a list of documents we will accept to verify eligibility are available at **www.hca.wa.gov/pebb.**

| **A** | **Relationship to subscriber** | Disabled? *Check only if age 26 or older* ❑ Yes ❑ No | Extended dependent validated by court order? ❑ Yes ❑ No | Social Security number |
|---|---|---|---|---|
| Last name | First name | Middle initial | Sex ❑ M ❑ F | Date of birth (mm/dd/yyyy) |
| Street address (only if different from subscriber) Apt./unit number | City | State | ZIP Code | |

**Medical coverage** ❑ Cover ❑ Remove from medical Reason _____

**Dental coverage** ❑ Cover ❑ Remove from dental Reason _____

**Tobacco Use Premium Surcharge**

**Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.)** Check one:

❑ **YES, I am subject to the $25 premium surcharge**. This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

| **B** | **Relationship to subscriber** | Disabled? *Check only if age 26 or older* ❑ Yes ❑ No | Extended dependent validated by court order? ❑ Yes ❑ No | Social Security number |
|---|---|---|---|---|
| Last name | First name | Middle initial | Sex ❑ M ❑ F | Date of birth (mm/dd/yyyy) |
| Street address (only if different from subscriber) Apt./unit number | City | State | ZIP Code | |

**Medical coverage** ❑ Cover ❑ Remove from medical Reason _____

**Dental coverage** ❑ Cover ❑ Remove from dental Reason _____

**Tobacco Use Premium Surcharge**

**Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.)** Check one:

❑ **YES, I am subject to the $25 premium surcharge**. This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

*(continued)*

| Subscriber's last name | First name | Middle initial | Social Security number |
|---|---|---|---|
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## Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

**C**

| Relationship to subscriber | Disabled? *Check only if age 26 or older* ❑ Yes ❑ No | Extended dependent validated by court order? ❑ Yes ❑ No | Social Security number |
|---|---|---|---|
| | | | |

| Last name | First name | Middle initial | Sex ❑ M ❑ F | Date of birth (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |

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

**Medical coverage** ❑ Cover ❑ Remove from medical Reason _____

**Dental coverage** ❑ Cover ❑ Remove from dental Reason _____

**Tobacco Use Premium Surcharge**

**Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.)** Check one:

❑ **YES, I am subject to the $25 premium surcharge**. This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

**D**

| Relationship to subscriber | Disabled? *Check only if age 26 or older* ❑ Yes ❑ No | Extended dependent validated by court order? ❑ Yes ❑ No | Social Security number |
|---|---|---|---|
| | | | |

| Last name | First name | Middle initial | Sex ❑ M ❑ F | Date of birth (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |

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

**Medical coverage** ❑ Cover ❑ Remove from medical Reason _____

**Dental coverage** ❑ Cover ❑ Remove from dental Reason _____

**Tobacco Use Premium Surcharge**

**Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.)** Check one:

❑ **YES, I am subject to the $25 premium surcharge**. This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

*(continued)*

| Subscriber's last name | First name | Middle initial | Social Security number |
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## Section 4: Medical Plan Selection *Check only one.*

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

**Kaiser Foundation Health Plan of the Northwest**[1]

- ❑ Kaiser Permanente NW Classic[2]
- ❑ Kaiser Permanente NW Consumer-Directed Health Plan[2]

**Kaiser Foundation Health Plan of Washington**
(formerly Group Health Cooperative)[1]

- ❑ Kaiser Permanente (formerly Group Health) WA Classic
- ❑ Kaiser Permanente WA (formerly Group Health) SoundChoice
- ❑ Kaiser Permanente WA (formerly Group Health) Value

**Kaiser Foundation Health Plan of Washington Options, Inc.**
(formerly Group Health Options, Inc.)[1]

- ❑ Kaiser Permanente WA (formerly Group Health) 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[1]
- ❑ UMP Plus–UW Medicine Accountable Care Network[1]

[1] These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must report your new address to your personnel, payroll, or benefits office **no later than 60 days** after you move. If your chosen plan has a change in contracted service area, you may need to change your plan. You must select a new plan within 60 days of the plan becoming unavailable in your area.

[2] Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.

## Section 5: Dental Plan Selection *Check only one.*

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

**Preferred Provider Organization**

- ❑ **Uniform Dental Plan** (Group #3000), administered by Delta Dental of Washington
  (You may receive services from any provider.)

**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** (Group #3100), administered by Delta Dental of Washington
  Call DeltaCare at 1-800-650-1583 to verify your provider is in the DeltaCare PEBB network.
  (You must receive services from a DeltaCare network provider.)
- ❑ **Willamette Dental** of Washington, Inc. (Group WA82), administered by Willamette Dental Group.
  Call Willamette at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.
  (You must receive services from a Willamette Dental Group plan provider.)

***Please sign and date the next page.***

*(continued)*

## 2018 Employee Enrollment/Change

| Subscriber's last name | First name | Middle initial | Social Security number |
|---|---|---|---|
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### Section 6: Signature *Required*

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 Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. 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, the PEBB Program or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

If adding a state-registered domestic partner to my account, I declare that my domestic partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until verification of the family member's eligibility is successful. I understand that if I'm applying to add a dependent to my PEBB insurance coverage, I must provide copies of documents that verify the dependent's eligibility within the PEBB Program's enrollment timelines, or the dependent will not be enrolled.

Employees must enroll in PEBB dental, basic life, and basic long-term disability insurance. However, employees may waive PEBB medical if they are enrolled in other employer-based group medical, TRICARE, or Medicare. If I waive medical, I understand I can enroll during the annual open enrollment period or no later than **60 days** after a special open enrollment event as defined in PEBB Program rules. If I waive medical for myself, I cannot enroll my eligible family members in medical.

I allow my employer to deduct money from my earnings to pay for insurance coverage and any applicable premium surcharges.

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 my employer will contribute 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.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

This form replaces all *Employee Enrollment/Change* forms previously submitted.

**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/pebb.**

**Subscriber's signature** _____ **Date** _____

***Please sign and date.***
***Return completed form and documentation to your personnel, payroll, or benefits office.***

### 2018 PEBB Program Medical Contractors

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

**Kaiser Foundation Health Plan of Washington**
**(formerly Group Health Cooperative)**
601 Union St., Suite 3100, Seattle, WA 98101-1374
1-888-901-4636 or TTY: 1-800-833-6388

**Kaiser Foundation Health Plan of Washington Options, Inc.**
**(formerly Group Health Options Inc.)**
601 Union St., Suite 3100, Seattle, WA 98101-1374
1-888-901-4636 or TTY: 1-800-833-6388

**Uniform Medical Plan, administered by Regence BlueShield**
1800 Ninth Avenue, Suite 235, Seattle, WA 98101
1-888-849-3681 or TRS: 711

### 2018 PEBB Program Dental Contractors

**DeltaCare, administered by**
**Delta Dental of Washington**
400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371
1-800-650-1583

**Uniform Dental Plan, administered by**
**Delta Dental of Washington**
400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371
1-800-537-3406

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

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please call 1-800-200-1004 (TRS: 711).