Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

A

2016 Retiree Coverage Election/Change

- **Use this form to enroll, defer, or make changes to PEBB retiree insurance coverage.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- If you are applying to enroll in retiree health insurance, the PEBB Program must receive this form **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are deferring enrollment in PEBB retiree health insurance, the PEBB Program must receive this form **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. You must maintain continuous enrollment in other qualifying insurance coverage (see Section 1). Complete required sections below, Sections 1 and 9, and if applicable, Sections 7 and 8.
- If you are applying to enroll in retiree health insurance after a deferral, the PEBB Program must receive this form **no later than 60 days** after your other qualifying insurance coverage ends (see Section 1 of this form).
- List eligible family members you wish to cover or remove from coverage. This form replaces all election forms previously submitted.
- If you are a surviving spouse, surviving registered domestic partner as defined in WAC 182-12-260(2), or surviving dependent, provide the Social Security number (SSN) of the deceased retiree or employee in the "Retiree or employee information only" section below. Provide your SSN in Section 1: Subscriber Information.

Additional forms or documents you may need to complete and submit:

- If enrolling in a plan that offers Medicare Advantage, submit the *Medicare Advantage Plan Election Form* (form C).
- If enrolling in the Premera Blue Cross Medicare Supplement Plan F, submit the *Group Medicare Supplement Enrollment Application* (form B).
- If enrolling a registered domestic partner or the partner's child, submit the *Declaration of Tax Status* form.
- If adding a dependent with a disability age 26 or older, submit the *PEBB Certification of Dependent With a Disability* form.
- If adding an extended dependent, submit the *Extended Dependent Certification* form.
- **A list of documents we will accept to show proof of a dependent's eligibility is in the *2016 Retiree Enrollment Guide* and on our website.**

These forms are available at
www.hca.wa.gov/pebb
or by calling 1-800-200-1004.

Required **Check one:**

- ☐ I am a new retiree or a surviving dependent applying to **enroll** in coverage.
- ☐ I am a new or existing retiree or a surviving dependent **deferring** my coverage.
- ☐ I am **changing** an existing account (such as canceling coverage, or adding or removing a family member).
- ☐ I am **enrolling after deferring** PEBB retiree coverage. Date other coverage ended _____ (mm/dd/yyyy).
- ☐ I am eligible under Plan 3, **separating** as of _____ (mm/dd/yyyy).

Required			
Retiree or employee information only	Retiree or employee name		
	Social Security number	Retirement plan	Retirement date (mm/dd/yyyy)
For new Washington State school district or educational service district (ESD) retirees only	School district		
	When does your current medical/dental coverage through your school district, ESD, or COBRA end? _____ (mm/dd/yyyy). **Note:** If you are applying to enroll in retiree insurance coverage after your COBRA coverage ends, you must submit proof of your continuous health coverage with this form.		

(continued)

2016 Retiree Coverage Election/Change

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 than above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Home phone number (including area code) ( )	Alternate phone number (including area code) ( )

Section 1: Enrollment Election/Change *Check the boxes that apply to you.*

❑ **Enroll:** ❑ Medical only ❑ Medical and dental ❑ Retiree term life insurance (also complete Sections 7, 8 and 9)

❑ **Defer my coverage.** Identify below your medical coverage that allows you to defer PEBB retiree coverage. Except as stated below, this defers coverage for all family members.
Deferral date _____

❑ **Enroll after deferring coverage.** Identify below the medical coverage you have been enrolled in since deferring enrollment in PEBB retiree coverage.

Date other coverage ended _____

If deferring, or enrolling after deferring, check the box below that applies to you. When enrolling after deferring, you must provide proof of continuous coverage since your date of deferral (begin and end dates).

❑ Enrolled in a PEBB, Washington State school district, or ESD-sponsored medical plan as a dependent.

❑ Enrolled in an employer-based group health plan as an employee or employee's dependent, including COBRA coverage or continuation coverage. This does not include an employer's retiree coverage.

❑ Enrolled in medical coverage as a retiree or dependent in TRICARE or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in PEBB retiree coverage.

❑ Enrolled in Medicare Part A and Part B, and a Medicaid program that provides creditable coverage. (You may continue to cover eligible family members in a PEBB plan if they are not eligible for creditable coverage under Medicaid.)

❑ Non-Medicare retirees only: Enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll in PEBB retiree coverage.

❑ **Cancel: I am enrolled in PEBB retiree coverage; I want to make the following change(s):**

❑ **Cancel medical** (if enrolled in only medical) **and dental coverage** (if enrolled in both). Cancel date: _____
I understand I am forfeiting all further rights to enroll again unless I regain eligibility. Coverage is automatically canceled for any enrolled dependents.

❑ **Cancel dental coverage for myself and any dependents.** Cancel date: _____
I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB retiree dental plan for at least two years or if I am deferring or disenrolling from my PEBB coverage as allowed under PEBB rules (see section 6). If I cancel for myself, dental is automatically canceled for my enrolled dependents.

❑ **Cancel retiree term life insurance.**

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of your Medicare card to this form if we don't already have a copy.	Part A (hospital)	❑ Yes	❑ No	If yes, effective date _____
	Part B (medical)	❑ Yes	❑ No	If yes, effective date _____
Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross.		❑ Yes	❑ No	If yes, effective date _____
Enrolled in Medicaid with Medicare Part D?		❑ Yes	❑ No	If yes, effective date _____
Receiving Social Security Disability?		❑ Yes	❑ No	If yes, effective date _____

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B and 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 with the exception of religious or ceremonial use. If you check YES below or leave this section blank, you will pay the surcharge. See the 2016 Premium Surcharge Help Sheet *for instructions on how to respond.*

Does the tobacco use premium surcharge apply to you? Read each option carefully and check only one:

❑ I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

❑ 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*.

(continued)

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

Section 2: Spouse or Registered Domestic Partner Information

List an eligible spouse or registered domestic partner (as defined in WAC 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 you are not enrolled in Medicare Part A and Part B you must provide proof of eligibility within PEBB's enrollment timelines to enroll a spouse or registered domestic partner.***

Relationship to subscriber ❑ Spouse: date of marriage _____ ❑ Domestic partner: date registered _____

If adding a registered domestic partner, attach a completed *Declaration of Tax Status* form and proof of eligibility within PEBB's enrollment timelines.

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

Coverage for spouse or registered domestic partner ❑ Cover ❑ Remove. Attach a copy of divorce decree or dissolution of domestic partnership if removing a spouse or domestic partner for this reason. Effective date _____ Reason _____ Date of birth (mm/dd/yyyy)

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of the spouse or domestic partner's Medicare card to this form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. ❑ Yes ❑ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date _____

Does the tobacco use premium surcharge apply to your spouse or domestic partner? Read each option and check only one:

❑ The subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

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

❑ NO, or my spouse or registered domestic partner have 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 you are not enrolled in Medicare Part A and Part B and your spouse or registered domestic partner has chosen 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 *in the* 2016 Retiree Enrollment Guide *or at* **www.hca.wa.gov/pebb** *for instructions. If you check YES below or leave this section blank, you will pay the monthly surcharge.*

Does the spouse or domestic partner coverage surcharge apply to you? Read each option carefully and check only one:

❑ The subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

❑ I previously attested to the spousal coverage premium surcharge and my attestation has not changed.

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

❑ 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 *2016 Spousal Plan Calculator* found at **www.hca.wa.gov/pebb**.

Section 3: Family Member Information *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. ***If you are not enrolled in Medicare Part A and Part B, you must provide proof of your family member's eligibility within PEBB's enrollment timelines or your family member will not be enrolled.*** *If enrolling a domestic partner's child, attach a completed* Declaration of Tax Status *form. 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. Attach an* Extended Dependent Certification *form if enrolling an extended dependent.*

1	**Relationship to subscriber**	Last name	First name	Middle initial

Social Security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	*(Check only if age 26 or older)* Disabled? ❑ Yes ❑ No	Extended dependent validated by court order? ❑ Yes ❑ No

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

(continued)

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

Section 3: Family Member Information *(continued)*

Coverage for family member ❑ Cover ❑ Remove Effective date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of family member's Medicare card to this form.
Part A (hospital) ❑ Yes ❑ No If yes, effective date _____
Part B (medical) ❑ Yes ❑ No If yes, effective date _____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. ❑ Yes ❑ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date _____

Does the tobacco use premium surcharge apply to this family member?
Response required for family members ages 13 or older. Read each option carefully and check only one:

❑ The subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

❑ YES, this family member has used tobacco products in the past two months.

❑ NO, this family member has used the tobacco cessation resources noted in the *2016 Premium Surcharge Help Sheet*.

2 **Relationship to subscriber** | Last name | First name | Middle initial

Social Security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	*(Check only if age 26 or older)* Disabled? ❑ Yes ❑ No	Extended dependent validated by court order? ❑ Yes ❑ No

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

Coverage for family member ❑ Cover ❑ Remove Effective date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of family member's Medicare card to this form.
Part A (hospital) ❑ Yes ❑ No If yes, effective date _____
Part B (medical) ❑ Yes ❑ No If yes, effective date _____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. ❑ Yes ❑ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date _____

Does the tobacco use premium surcharge apply to this family member?
Response required for family members ages 13 or older. Read each option carefully and check only one:

❑ The subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

❑ YES, this family member has used tobacco products in the past two months.

❑ NO, 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

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

❑ Remove dependent(s). In most cases, when removing a dependent from coverage the change will occur prospectively. If removing a dependent due to loss of eligibility (divorce, dissolution of domestic partnership, death, or other loss of eligibility for PEBB benefits), you must submit 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 canceled the last day of the month of loss of eligibility.
If applicable, provide former dependent's new address: _____

(continued)

2016 Retiree Coverage Election/Change

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

Additional changes you can make if an event creates a special open enrollment
The PEBB Program only allows changes outside of an annual open enrollment when an event creates a special open enrollment. The PEBB Program must receive this form and proof of the event that created the special open enrollment **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 date of the birth or adoption.

Check the box next to each change you are requesting, and indicate the corresponding event(s) below. 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) ❑ Change medical and/or dental plan Give date of event _____

The following events allow a subscriber to add a dependent and change a medical and/or dental plan:

- ❑ Marriage, registering a domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ❑ Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete *Extended Dependent Certification* form available at **www.hca.wa.gov/pebb**.
- ❑ Child becoming eligible as a dependent with a disability. Also complete *Certification of Dependent With a Disability* form available at **www.hca.wa.gov/pebb.**
- ❑ Dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ❑ Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward employer-based group health insurance.
- ❑ A court order or National Medical Support Notice requiring the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ❑ Subscriber or dependent becoming entitled to or losing eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ Subscriber or dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

The following events allow a subscriber to add a dependent:

- ❑ Dependent having a change in enrollment under other employer-based group health insurance during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ❑ Subscriber's dependent moving from outside the United States to live within the United States.

The following events allow a medical and/or dental plan change:

- ❑ Subscriber or dependent having a change in residence that affects health plan availability.
- ❑ 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).
- ❑ Subscriber or dependent becoming entitled to or losing eligibility for Medicare, or enrolling in or canceling enrollment in a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).

Section 5: Medical Plan Selection *Check appropriate box(es).*

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

Group Health Cooperative
- ❑ Group Health Classic
- ❑ Group Health Medicare Plan[1,2]
- ❑ Group Health SoundChoice[6]
- ❑ Group Health Value

Group Health Options Inc.
- ❑ Group Health Consumer-Directed Health Plan[3]

Kaiser Foundation Health Plan of the Northwest
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan[3]
- ❑ Kaiser Permanente Senior Advantage[1]

❑ **Medicare Supplement Plan F, administered by Premera Blue Cross[4]**

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan[3]
- ❑ UMP Plus-Puget Sound High Value Network[5]
- ❑ UMP Plus-UW Medicine Accountable Care Network[5]

[1] These Medicare Advantage plans are available in certain counties to Medicare enrollees. Also complete and attach form C if you live in a county where Medicare Advantage is available. (See *Retiree Enrollment Guide* for a list.)

[2] If you cover family members not enrolled in Medicare Part A and Part B, also select Group Health Classic, SoundChoice or Value for these family members.

[3] These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation of coverage options.

[4] Also complete and return form B to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.

[5] This plan is not available to Medicare Part A and Part B retirees and their dependents.

[6] This plan is available only if at least one covered family member is not enrolled in Medicare Part A and Part B. Family members enrolled in Medicare Part A and Part B will be enrolled in Group Health's Medicare Plan.

(continued)

2016 Retiree Coverage Election/Change

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

Section 6: Dental Plan Selection *Check only one.* ***You must enroll in medical coverage to enroll in dental.***

If you select retiree dental coverage for yourself, **you must keep dental coverage for yourself and any enrolled dependents for at least two years** unless you defer or cancel enrollment in PEBB coverage as allowed under PEBB rules. However, you may change retiree dental plans within those two years.

Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans for benefits information; their contact information is located at the end of this form.

Preferred Provider Organization

❑ Uniform Dental Plan, administered by Delta Dental of Washington (Group #3000)
You can choose any dental provider and change providers at any time.

Managed-Care Plans

❑ DeltaCare, administered by Delta Dental of Washington (Group #3100)
You must select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, 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.
Clinic location _____
You must select and receive care from a primary care dental provider in the Willamette Dental Group plan.

Section 7: Retiree Term Life Insurance Election

Retiree term life insurance is only available if you received PEBB employee life insurance. The cost is $7.75 per month (premium guaranteed through December 31, 2016), regardless of age.

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plans are not eligible for this retiree term life insurance plan.

Age at death	Beneficiary paid
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

This insurance has no cash value, and is not available for your dependents.

I elect to enroll in the PEBB retiree term life insurance plan. ❑ Yes ❑ No

Beneficiary name	Beneficiary's Social Security number
Relationship to subscriber	Beneficiary's date of birth
Beneficiary's address	

Section 8: Payment Authorization

How would you like to pay your premium and any applicable surcharges?	How to make the first payment
❑ I authorize the Department of Retirement Systems to deduct premiums and any applicable surcharges I am required to pay from my **retirement pension.** Deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.	If you select pension deduction, the PEBB Program will send you an invoice if a first payment is needed.
❑ I will pay my premium and any applicable surcharges monthly by **check. I must make the first payment before I will be enrolled.** ❑ I will pay my monthly premium and any applicable surcharges by **electronic funds transfer**. **I must make the first payment before I will be enrolled** and will complete and submit the *Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*.	If you select one of the options at the left, make your check **payable to Health Care Authority** and send with your forms to: Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695

Note: You can not have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage, COBRA coverage, or continuation coverage ended. Premiums and any applicable surcharges are for a full month of coverage and cannot be prorated for a partial month. Payments are processed immediately as required by state law.

(continued)

2016 Retiree Coverage Election/Change

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

Section 9: 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 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, 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 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, and denial of PEBB benefits.

If I send payment, this does not mean 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 of premium payments.

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 not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, I must remain enrolled in retiree dental for at least two years unless I defer coverage as described in Section 1, or enroll in employer-based group dental insurance or such coverage continued under COBRA as an employee or dependent of an employee.

I understand if I or any enrolled family member is entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.

If I choose to defer medical/dental, I understand I can enroll or reenroll no later than **60 days** after losing other health coverage or during the annual open enrollment period as long as there has been no gap in coverage and I provide proof of continuous enrollment. The PEBB Program must receive my enrollment form no later than 60 days after other coverage ends, or the last day of the annual open enrollment period.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand the PEBB Program will direct a portion of my monthly premium to an HSA 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.

If I die, my eligible surviving family members must complete the *Retiree Coverage Election/Change* form to enroll in or defer PEBB retiree health insurance coverage. The PEBB Program must receive the form no later than **60 days** after my death.

This form replaces all *Retiree Coverage Election Forms* previously submitted to PEBB.

If I am a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with the DRS to better serve me.

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** _____

Be sure to sign and date this form. Mail completed form and documentation to:

Washington State Health Care Authority PEBB Program, P.O. Box 42684, Olympia, WA 98504-2684 **or fax to:** 360-725-0771

Questions? Visit our website at **www.hca.wa.gov/PEBB** or call us at 1-800-200-1004

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

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

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

2016 PEBB Dental Contractors

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

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

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

2016 PEBB Life Insurance Contractor

ReliaStar Life Insurance Company
20 Washington Avenue South, Route 4-N, Minneapolis, MN 55440-0020 (Policy Form #LP00GP)
1-866-689-6990