



Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read and sign the back of this form.

Section 1: Retiree information				Medical/dental effective date (mm/dd/yyyy)	
Social Security number	Last name (as appears on Medicare card)		First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Permanent residential address		Apt./unit number	City	State	ZIP Code + 4
Mailing address (if different than above)		Apt./unit number	City	State	ZIP Code + 4
County of residence	Date of birth (mm/dd/yyyy)	<input type="checkbox"/> Married (mm/dd/yyyy)		Home phone number (including area code)	
Retiree Medicare claim number	Entitled to Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				
	Entitled to Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				

Section 2: Spouse information					
Social Security number	Last name (as appears on Medicare card)		First name	Middle initial	
Permanent residential or mailing address			Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
City			State	ZIP Code + 4	
Spouse Medicare claim number	Entitled to Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				
	Entitled to Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				

Section 3: Plan choice					
I wish to enroll in: Group Health Cooperative <input type="checkbox"/> Group Health Medicare Advantage PEBB Retiree (HMO) Kaiser Foundation Health Plan of the Northwest <input type="checkbox"/> Kaiser Permanente Senior Advantage (HMO) I wish to cancel my current medical coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No			I wish to enroll in: <input type="checkbox"/> DeltaCare, administered by Delta Dental of Washington Dentist name or clinic code _____ <input type="checkbox"/> Uniform Dental Plan, administered by Delta Dental of Washington <input type="checkbox"/> Willamette Dental of Washington, Inc. Clinic location _____		
Name of RETIREE'S contracting primary care provider (PCP) (refer to plan's provider directory)				Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of SPOUSE'S contracting primary care provider (PCP) (refer to plan's provider directory)				Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 4: Medical information		Retiree	Spouse
1. Do you currently have end-stage renal disease (kidney disease)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have any health insurance other than Medicare?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, through which company?		What type of policy?	
Do you intend to discontinue this policy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Note: Your answers to questions #3 and #4 below will not affect your eligibility to enroll in a Medicare Advantage plan.			
3. Do you live in an institution?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, name of institution		Date of admission	
Address		Phone number	
4. Are you currently receiving Medicaid?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Medicaid number			

Signature and authorization

I authorize Department of Retirement Systems to deduct from my retirement pension the amount required to pay for this coverage. Yes, deduct from my pension. No, I will send my payment monthly.

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 law, 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 qualified. 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.

We have read and understand this form, including the Statement of Understanding below. We know that we must refer to our plan's certificate of coverage for rules we must follow to receive coverage under this Medicare Advantage contract.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS to better serve you.

This form cannot be signed more than 90 days before the effective date of this coverage.

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.

Signature of applicant	Date	Signature of spouse	Date
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I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where he or she resides) on this application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from the Medicare Advantage plan or by Medicare.

Signature of individual who assisted the applicant and/or spouse in completing this form	Date
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If you are the authorized representative, you must sign above and provide the following information:

Name	Relationship to applicant
Address	Phone

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare Advantage plan will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage plan will release my information to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize the CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including—but not limited to—physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during PEBB's annual open enrollment, then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

Please contact the plans listed on the previous page if you need information in another language or format.

Group Health Cooperative and Kaiser Foundation Health Plan of the Northwest are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.

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

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
1-877-221-8221 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

Please return this form by mail to:

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