Washington State Health Care Authority
Public Employees Benefits Board

Life Claim Information Sheet

See the back of this form for instructions and definitions.

Employers must complete this form when reporting a waiver of life insurance premium claim, accelerated life claim, or the death/dismemberment claim of an employee or covered dependent. Submit this form to the PEBB Program with:

1) Copies of **all** original life insurance enrollment form(s), and
2) Original certified death certificate, if submitting a death claim.

Employee Information

Agency/subagency code	Agency name

Social Security number	Name (last, first, middle initial)	Marital status ❑ Married ❑ Registered domestic partner ❑ Never married ❑ Divorced ❑ Widow(er)

Street address	Apt./Unit number	City	State	ZIP Code

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

Date of birth (mm/dd/yyyy)	Home phone number ( )	Employment status ❑ Full time ❑ Part time	Labor status ❑ Union ❑ Non union

Current agency hire date	Employment start date	Original hire date (unbroken service date)	Original insurance eligibility date (first day of eligibility with state service)

Last day physically on the job	Reason for stopping work	Current job title

Monthly salary as of last day physically on the job	Date of last salary change (prior to last day physically on the job)	Salary prior to last increase
$		$

Type of Claim

❑ **Life waiver of premium** ❑ **Accelerated life claim** ❑ **Death claim** ❑ **Dismemberment claim**

Name of deceased or injured person	Other names the insured may have been known by

Relationship to employee	Date of illness/injury/death (mm/dd/yyyy)	Employee status at date of illness/injury/death: ❑ Active ❑ Retired ❑ Disability waiver of premium ❑ FMLA

Have premiums been paid to the date of illness/injury/death? ❑ Yes ❑ No	If no, to what date have premiums been paid?	If a dependent, date of birth	Dependent's Social Security number

Employee Basic Life	Employee Basic AD&D	Spouse Basic Life ❑ Yes ❑ No	Children Basic Life ❑ Yes ❑ No
$	$	$	$

Employee Supplemental AD&D ❑ Yes ❑ No	Dependents Supplemental AD&D ❑ Yes ❑ No	Retiree Term Life ❑ Yes ❑ No
$	$	$

Beneficiary name	Beneficiary's date of birth (mm/dd/yyyy)	Beneficiary's relationship to employee

Beneficiary's Social Security number	Beneficiary's phone number	Beneficiary's email address

Beneficiary's street address (only if different from subscriber)	Apt./Unit number	City	State	ZIP Code

Name of person completing this form (type or print)	Phone number	Date

Complete this form and mail it with the documents requested above to:
Health Care Authority, Attn.: PEBB Program Outreach & Training, P.O. Box 42684, Olympia, WA 98504-2684

Instructions

Life waiver: File a claim if an employee is under 60 years old on their last day physically on the job **(including terminations or resignations)** and the employee cannot work for six months or longer due to a disability or illness, or at the employee's or PEBB Program's request.

Complete the *Life Claim Information Sheet*. Include copies of **all life enrollment form(s)**, that is, all life forms that the employee has completed within state service. If copies are not available, provide proof of payment of premiums for life coverage from the effective date.

Accelerated life claim: Employee **must** send a letter to the PEBB Program to file the claim.

Definitions

Current agency hire date: First day of employment with your state agency, political subdivision, K-12 school district, educational service district, or higher-education institution.

Original hire date: First day of employment with a state agency, political subdivision, K-12 school district, educational service district, or higher-education institution, even if the employee was not eligible for benefits.

Original insurance eligibility date: First day the employee became eligible for insurance benefits.

Last day physically on the job: Last day the employee physically worked (**not** the last day in pay status) or had hours reduced or duties modified because of a disability. Employees may use sick leave, annual leave, shared leave, and Family and Medical Leave Act (FMLA) leave after their last day physically on the job.

Return to work (RTW): If an employee returns to work **before** filing a long-term disability claim, the PEBB Program needs to know whether the employee returned to work in a full-time, part-time, light duty, restricted duty, or regular duty status.

Monthly salary: Monthly wages as of the employee's **last day physically on the job**, or the date the employee had hours reduced or duties modified because of a disability.

Date of last salary change: Date the employee's wages changed **before** the employee's last day physically on the job, or the date the employee had hours reduced or duties modified because of a disability.