

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** after the date your employer-sponsored coverage ends or from the postmark on the *PEBB Continuation of Coverage Election Notice* packet sent to you, whichever is later.
- We must receive your first payment before we can enroll you. Premiums and applicable surcharges are due back to the date your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all COBRA Continuation or Extension of Coverage Election/Change forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form(s).

All forms and documents are available at www.hca.wa.qov/pebb or by calling 1-800-200-1004.

Employee	Employ	ee or retiree name				
or retiree information only	Employ	ee or retiree Social Security	number	Date employer coverage ended (mm/dd/yyyy)		
Section 1: Subs	criber	Information				
Social Security number Last name		First name		Midd	lle initial Sex	
Street address		Apt./unit number	City		State	ZIP Code
Mailing address (if diff	ferent fro	om above) Apt./unit number	City		State	ZIP Code
County of residence		Date of birth (mm/dd/yyyy)	Daytime phone numb	oer	Home pho	one number)
☐ Continue coverd	ı ge: (se	lect one) 🔲 Medical and d	ental 🔲 Medical o	nly 🔲 Dent	al only	
optional life insurance and wish to continue it, complete and submit the <i>Group Life Portability Application</i> (available from your former employer). The insurer must receive the form no later than 31 days after your employer-sponsored coverage ends. If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions no later than 60 days after the date they provide you with the notice of your continuation right. Cancel coverage: (select one) Medical and dental Medical only Dental only						
Reason			II. DEDD I G		ncel date	
		eiting all further rights to en				
Are you covered by o						
Are you covered by o		· · · · · · · · · · · · · · · · · · ·				
Are you disabled und Security Act?	ler Title	II (OASDI) of the Social				
Are you disabled under Title XVI (SSI) of the Social Security Act? Yes No If yes, effective date						
If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.						
Enrolled in Part(s) A Medicare?	and/or E	3 of Part A (hospit	tal) 🔲 Yes 🔲 No	If yes, effective	date	
r redicure:		Part B (medic	al) 🔲 Yes 🔲 No	If yes, effective	date	
	lf y	es, proof is required. Attach	a copy of your Medica	are card to this	form.	

HCA 50-245F (1/16) (continued)

Subscriber's last name		First name		Middle initial	Social Secur	ity number
Section 1: Subscri	ber Informa	tion (continued)				
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 except for religious or ceremonial use. See the 2016 Premium Surcharge Help Sheet at www.hca.wa.gov/pebb for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.						
Does the tobacco use premium surcharge apply to you? Check 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.						
Saction 2. Snauce	ou Dogistous	nd Domostic Da	utnau Infaun			
Section 2: Spouse or Registered Domestic Partner Information List an eligible spouse or 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 registered domestic partner, you must provide proof of eligibility within PEBB's enrollment timelines, or the registered domestic partner will not be enrolled. A list of documents we will accept to verify eligibility is available at www.hca.wa.gov/pebb.						
Relationship to subscr	riber					
☐ Spouse: date of marriag	ge	Regis	tered domestic p	artner: date regis	stered	
Social Security number	Last name	First name	Mide	dle initial Date o	f birth (mm/dd/	yyyy) Sex
Street address		Apt./unit number	City	,	State	ZIP Code
Continue coverage Add coverage: (sele Cancel coverage: (s	ect one) select one)	Medical and dental Medical and dental Medical and dental	Medical o Medical o Medical o	nly	only only el date	attach a conv of
If removing a spouse or registered domestic partner due to a divorce or dissolution of domestic partnership, attach a copy of the divorce decree or dissolution of registered domestic partnership.						
Covered by another grou	up medical plan?			•		
Covered by another grou	up dental plan?		Yes No	If yes, effective of	late	
Disabled under Title II (-	-		•		
Disabled under Title XV		*				11.0
If yes, you must ser You	nd a copy of the s and your enrolle	pouse's or registered d dependents may be	domestic partne eligible for addit	er's Social Securit tional months of	ty Disability A coverage.	Award letter.
Enrolled in Part(s) A and of Medicare?	l/or B	Part A (hospital) Part B (medical)				
If ye	es, proof is require	ed. Include a copy of the Medicare card	e spouse's or reg	•		
Tobacco Use Premium Surcharge						
Does the tobacco use pre The subscriber is enrol YES, my spouse or regi NO, or my spouse or re Surcharge Help Sheet.	emium surcharge led in Medicare Po istered domestic p	art A and Part B. The poartner has used tobac	oremium surchar co products in t	ge does not appl he past two mon	y. ths.	6 Premium

Subscriber's last name	First name		Middle initial	Social Secu	urity number
	10 (10		4.		
Section 2: Spouse or Registe			mation (conti	nued)	
Spouse or Registered Domestic Partner		_			5
The PEBB Program requires a monthly \$50 Part B, and your spouse or registered dom is comparable to Uniform Medical Plan Claat www.hca.wa.gov/pebb. To change you leave this section blank, you will pay the new thick the section blank.	nestic partner has elected assic. See the 2016 Pren our attestation, use the 2	d not to enroll in nium Surcharge I	other employer-b Help Sheet and th	ased group m e 2016 Spou	edical insurance that sal Plan Calculator
Does the spouse or registered domestic partner coverage surcharge apply to you? Check one: ☐ The subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply. ☐ YES, I used the 2016 Premium Surcharge Help Sheet and completed the 2016 Spousal Plan Calculator online. ☐ 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 printed 2016 Spousal Plan Calculator from www.hca.wa.gov/pebb.					
Section 3: Family Member Information (such as child) <i>Use additional forms for more members.</i> 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. Attach a completed Extended Dependent Certification form if enrolling an extended dependent. 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.					
A Relαtionship to subscriber	Check only if a Disabled?		Sex F	Social Secu	urity number
Extended dependent validated by court)			
Last name	First name		Middle initial	Date of bir	rth (mm/dd/yyyy)
Street address (only if different from subs	criber) Apt./unit number	City		State	ZIP Code
☐ Continue coverage: (select one)	☐ Medical and denta	l 🔲 Medical	only 🔲 Dento	ıl only	
Add coverage: (select one)	☐ Medical and denta	_	, <u> </u>	•	
Cancel coverage: (select one)	☐ Medical and denta	_	, —	•	
Reason Covered by another group medical pla		☐ Yes ☐ No			
Covered by another group dental plan		Yes No			
Disabled under Title II (OASDI) of the		Yes No			
Disabled under Title XVI (SSI) of the S	•	Yes No	•		
If yes, you must send	Disabled under Title XVI (SSI) of the Social Security Act? Yes No If yes, effective date If yes, you must send a copy of the family member's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.				
Enrolled in Part(s) A and/or B of	Part A (hospital)				
Medicare?	Part B (medical)	☐ Yes ☐ No	If yes, effective	date	
If yes, proof is requi	red. Attach a copy of the	e family member	r's Medicare card	to this form.	
Tobacco Use Premium Surcharge					
Does the tobacco use premium surchar	ge apply to this family	member? (Respo	nse required for fa	mily members	ages 13 or older.)

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

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

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

Check one:

First name

Subscriber's last name

Middle initial | Social Security number

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Section 3: Family Member Inform			L		
B Relationship to subscriber	Check only if ag Disabled? \(\begin{array}{c} \text{Y} \end{array}\)	e 26 or older. ′es	Sex ☐ M ☐ F	Social Secu	irity number
Extended dependent validated by court order?					
· · · · · · · · · · · · · · · · · · ·	First name		Middle initial	Date of bir	th (mm/dd/yyyy)
Street address (only if different from subscriber) A	Apt./unit number	City		State	ZIP Code
Add coverage: (select one)	dical and dental dical and dental dical and dental	☐ Medical o	only Dental	only only	
Covered by another group medical plan?		🔲 Yes 🔲 No	If yes, effective d	late	
Covered by another group dental plan?		☐ Yes ☐ No	If yes, effective d	late	
Disabled under Title II (OASDI) of the Social S	ecurity Act?	Yes No	If yes, effective d	late	
Disabled under Title XVI (SSI) of the Social Se	curity Act?	☐ Yes ☐ No	If yes, effective d	late	
If yes, you must send a copy o You and your enrolled dep	of the family me endents may be	mber's Social Se eligible for addi	curity Disability tional months of	Award letter coverage.	:
	t A (hospital)	Yes No	If yes, effective d	late	
Medicare?	t B (medical)	☐ Yes ☐ No	If yes, effective d	late	
If yes, proof is required. Attach a copy of the	family member	's Medicare card	to this form if we	e don't alrea	dy have a copy.
Tobacco Use Premium Surcharge					
Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 or older.) Check 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, or 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 exi	sting accou	nt?			
Yes If yes, what changes? (Check all that a No If no, go to Section 5.	•				
Changes you can make anytime	Giv	e date of event/c	hange		
☐ Name change ☐ Address change	☐ Cancel medi	•	Cancel de	ental coverac	 ge
Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of registered domestic partnership, death, or other loss of eligibility under PEBB rules), we must receive 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 cancelled the last day of the month of loss of eligibility. If applicable, provide former dependent's new address:					
Additional changes you can make	during annı	ıal open eni	rollment		
All changes become effective January 1 of the follow	ving year.	-			
Check the box(es) next to the change requested.					
Add dependent(s) Change medical	plan 🔲 Cł	nange dental pla	ın		

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

Section 4: Changes to an Existing Account (continued)

Additional 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 PEBB Program must receive this form and proof of the event 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 birth or adoption.

		n or adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.					
eac	Check the box next to each change you are requesting and indicate the corresponding event(s). See the numbers beside each change to verify that your requested change may be allowed. In most cases, the enrollment or change will be effective the irst day of the month after the event date or the date the form is received, whichever is later.						
	Add	dependent(s) (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10, 11)					
	Cha	nge medical plan (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14)					
	Cha	nge dental plan (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14)					
Giv	e da	te of event					
		the box(es) next to the corresponding event(s). The event number below must be listed next to the (s) you are requesting above.					
	1.	Marriage, registering a domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.					
	2.	Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete an <i>Extended Dependent Certification</i> form available at www.hca.wa.gov/pebb .					
	3.	Child becoming eligible as a dependent with a disability. Also complete a <i>Certification of Dependent With a Disability</i> form available at www.hca.wa.gov/pebb .					
	4.	Subscriber or dependent losing other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).					
	5.	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.					
	6.	Subscriber or dependent having a change in enrollment under another employer-based group health insurance during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.					
	7.	Subscriber's dependent moving from outside the United States to live within the United States or moving from inside the United States to live outside the United States.					
	8.	Subscriber or dependent having a change in residence that affects health plan availability.					
	9.	A court order or National Medical Support Notice requiring the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.					
	10.	Subscriber or dependent becoming entitled to or losing eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).					
	11.	Subscriber or dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.					
	12.	Subscriber or dependent becoming entitled to or losing eligibility for Medicare, or enrolling in or cancelling enrollment in a Medicare Part D plan.					
	13.	Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).					
	14.	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).					
Are	you	or any eligible dependents enrolled in PEBB coverage under another account? Yes No					

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

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	¹ These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the <i>Medicare Advantage Plan Election Form</i> (form C) if you live in a county where Medicare Advantage is available. (See www.hca.wa.gov/pebb for medical plans available by county.)				
	If you cover dependents not enrolled in Medicare Part A and Part B, also select Group Health Classic,				
☐ Kaiser Permanente Classic ☐ Kaiser Permanente Consumer-Directed Health Plan³ ☐ Kaiser Permanente Senior Advantage¹ ☐ Medicare Supplement Plan F, administered by Premera Blue Cross⁴	SoundChoice, or Value for these dependents. These plans are available only to members 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 coverage options.				
Uniform Medical Plan, administered by Regence BlueShield UMP Classic UMP Consumer-Directed Health Plan ³ UMP Plus-Puget Sound High Value Network ⁵	Also complete and return the <i>Group Medicare Supplement Enrollment Application</i> (form B) to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.				
☐ UMP Plus-UW Medicine Accountable Care Network ⁵	⁵ This plan is not available to Medicare Part A and Part B subscribers 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.				
Castian A. Dantal Dian Calastian or the					
Section 6: Dental Plan Selection Check only one.					
Before you select a dental plan, be sure your provider(s) participe	ate with that plan.				
Preferred Provider Organization You can choose any dental provider and change providers at any Uniform Dental Plan, administered by Delta Dental of Wasl					
Managed-Care Plans You must choose a provider from the dental plan network. Before dental plan to verify your provider is in their network and fill in the	ne requested information below.				
□ DeltaCare, administered by Delta Dental of Washington (Group #3100) 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. Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.					
Clinic location					

(continued)

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

Section 7: Signature Required

I have received and read the *PEBB Continuation of Coverage Election Notice*, including any appendices. 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). 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 it is a crime to knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of PEBB insurance benefits.

If I send payment, this does not mean that 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.

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

This form replaces all COBRA Continuation of Coverage or PEBB Extension of Coverage Election/Change forms previously submitted to the PEBB Program.

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.

Subscriber's signature	Date	
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Please sign and date this form.

Mail to:

Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684 If payment is enclosed, make it payable to Health Care Authority and mail to:

Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695

Or hand-deliver to:

Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

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 Ave., Suite 235, Seattle, WA 98101 1-888-849-3681 or TTY 711

2016 PEBB Dental Contractors

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

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

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