Clear form

2021 SEBB Continuation Coverage (COBRA) Election/Change

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

We must receive this form **no later than 60 days** from the date your SEBB health plan coverage ends or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent to you, whichever is later. Submission directions are located after the signature on this form.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends. We will not enroll you in coverage until we receive your first premium payment. If HCA does not receive your first payment during this 45-day timeframe, you will not be enrolled and you will lose your rights for SEBB Continuation Coverage (COBRA). Premiums and applicable premium surcharges are due from the date your other coverage ended.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted. Therefore, you must complete the entire form, including the dependent section for any children you want to continue to cover.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example: J O H N

All forms and documents are available on HCA's website at **hca.wa.gov/sebb-continuation** under *Forms & publications*, or by calling the SEBB Program at 1-800-200-1004 (TRS: 711).

Remember to read and sign Section 7. To enroll children, complete Section 8 on page 13.

School employee information only

Last name

First name

Social Security number

Date SEBB health plan coverage ended

1 Subscriber

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

1 *This field is required for health care services.*
2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

If you move, you must report your new address to the SEBB Program **no later than 60 days** after you move. You can report it by using this form, by sending a written request to the address listed on page 12 of this form, or by calling 1-800-200-1004 (TRS: 711).

Are you or your dependents enrolled in SEBB insurance coverage under another account?

Yes No

Continue coverage (Select all that apply.)

Medical Dental Vision

Add coverage (Select all that apply.)

Medical Dental Vision

Terminate coverage (Select all that apply.)

Medical Dental Vision

Termination date

If terminating coverage, include reason

You may elect to continue coverage you were enrolled in on the day your SEBB health plan coverage ended. If you have life insurance and wish to port or convert, call MetLife at 1-833-854-9624. If you are enrolled in a Medical Flexible Spending Arrangement (FSA) and would like to continue it, call Navia Benefit Solutions at 1-800-669-3539. Navia must receive your request **no later than 60 days** from the date your SEBB health plan coverage ended, or from the postmark date on Navia's COBRA election notice sent to you, whichever is later.

If you terminate all coverage, you will not be eligible to enroll again in SEBB Continuation Coverage unless you regain eligibility.

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Are you covered by another group medical plan?

Yes No If yes, effective date

Are you covered by another group dental plan?

Yes No If yes, effective date

Are you covered by another group vision plan?

Yes No If yes, effective date

Do you receive Social Security Disability?

Yes No If yes, effective date

If you answered **Yes** to receiving Social Security Disability, include a copy of your Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy so we can identify your account. You and your enrolled dependents may be eligible for additional months of coverage.

Are you enrolled in Medicare Part A or Part B?

Part A (hospital)

Yes No If Yes, enter effective date shown on the Medicare card:

Part B (medical)

Yes No If Yes, enter effective date shown on the Medicare card:

If you answered **Yes**, proof is required. Include a copy of your Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account.

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The SEBB Program requires a $25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your SEBB medical plan 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 a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the SEBB Program Administrative Policy 91-1 at **hca.wa.gov/sebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge. See the *2021 SEBB Premium Surcharge Attestation Help Sheet* available on HCA's website at **hca.wa.gov/sebb-continuation** for instructions on how to respond. To change your attestation, use the *2021 SEBB Premium Surcharge Attestation Change Form*.

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, submit the *SEBB Premium Surcharge Attestation Change Form*.

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

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or state-registered domestic partner (SRDP), as defined by WAC 182-31-020, you wish to enroll or remove from medical, dental, or vision coverage. To enroll children, please complete Section 8, located at the end of the form. Your spouse or SRDP cannot be enrolled in two SEBB Program medical, dental, or vision accounts at the same time.

Relationship to subscriber

☐ Spouse: date of marriage

☐ SRDP: date registered

If enrolling a SRDP, also submit a *2021 SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b). You must provide proof of their eligibility within the SEBB Program's timelines, or they will not be enrolled. A list of acceptable documents to verify eligibility is available on HCA's website at **hca.wa.gov/sebb-continuation**.

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber's)

Address line 2

City

State

ZIP/Postal code

County

Continue coverage (Select all that apply.)
☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)
☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)
☐ Medical ☐ Dental ☐ Vision

Termination date

If terminating coverage, include reason

If removing a spouse due to divorce, attach a copy of the divorce decree. If removing a SRDP due to a dissolution, attach a copy of the dissolution of state-registered domestic partnership.

1 *This field is required for health care services.*
2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Is this person covered by another group medical plan?

Yes No If yes, effective date

Is this person by another group dental plan?

Yes No If yes, effective date

Is this person covered by another group vision plan?

Yes No If yes, effective date

Does this person receive Social Security Disability?

Yes No If yes, effective date

If you answered **Yes** to receiving Social Security Disability, include a copy of their Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy so we can identify your account. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part A or Part B?

Part A (hospital)

Yes No If Yes, enter effective date shown on the Medicare card:

Part B (medical)

Yes No If Yes, enter effective date shown on the Medicare card:

If you answered **Yes,** proof is required. Include a copy of their Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account.

Tobacco use premium surcharge

Response required if enrolling your spouse or SRDP in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See the *2021 SEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/sebb-continuation** 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. This person has used tobacco products in the past two months. If this is a change to a previous attestation, please submit the *SEBB Premium Surcharge Attestation Change Form*.

No, I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Spouse or state-registered domestic partner (SRPD) coverage premium surcharge

Response required if you are enrolling your spouse or state-registered domestic partner (SRDP) in medical coverage. The SEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in SEBB medical, and they have chosen not to enroll in another employer-based group medical that is comparable to the Public Employees Benefits Board (PEBB) Program's Uniform Medical Plan (UMP) Classic. See the *2021 SEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond.

Does the spouse or SRDP coverage surcharge apply to you? Check one:

☐ **Yes**, I am subject to the $50 premium surcharge. I used the *SEBB Premium Surcharge Attestation Help Sheet* and completed the *2021 SEBB Spousal Plan Calculator*.

If you check **Yes** or do not check any boxes below, you will be charged the $50 spouse or SRDP coverage premium surcharge.

☐ **No**, I am not subject to the $50 premium surcharge.
I used the *SEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *SEBB Spousal Plan Calculator*.
Which questions, if any, on the *SEBB Premium Surcharge Attestation 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

☐ The SEBB Program to help determine if premium surcharge applies. I used the *SEBB Premium Surcharge Attestation Help Sheet* and am completing and submitting a printed *SEBB Spousal Plan Calculator*. The SEBB Program will use these to help determine whether my spouse's or SRDP's employer-based group medical is comparable to PEBB's UMP Classic and whether I am subject to the premium surcharge.

The *2021 SEBB Premium Surcharge Attestation Help Sheet* and *the 2021 SEBB Spousal Plan Calculator* are available on HCA's website at **hca.wa.gov/sebb-continuation** under *Forms & publications*.

Subscriber's last name

Social Security number

3 Changes to an existing account

Are you making changes to an existing account?

☐ Yes If yes, check all changes that apply in the sections below.

Date of event/change:

☐ No If no, continue to Section 4.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for you or your enrolled dependents

☐ Terminate vision coverage for you or your enrolled dependents

☐ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child), the SEBB Program must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility. Coverage will be terminated the last day of the month of loss of eligibility. If applicable, provide your former dependent's new address:

Street address

Address line 2

City State

ZIP/Postal code County

Additional changes you can make during the annual open enrollment

All changes become effective January 1 of the following year.
Check the boxes next to the changes requested.

☐ Add dependents

☐ Remove dependents

☐ Add or change medical plan

☐ Add or change dental plan

☐ Add or change vision plan

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Changes you can make if an event creates a special open enrollment (SOE)

The SEBB Program only allows changes outside of the annual open enrollment when an event creates a SOE. The SEBB Program must receive this form and proof of the event **no later than 60 days** after the event occurs.

To enroll a newborn or child whom you, the subscriber, have adopted or have assumed a legal responsibility for support ahead of adoption, you should notify the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth, adoption, or the date the legal responsibility for support is assumed ahead of adoption.

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.

Date of event/change:

Check the box next to the corresponding events below.

The following events allow a subscriber to enroll dependents or change medical, dental, or vision plans.

- Subscriber 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 (HIPAA).
- Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution under their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects the dependent's eligibility for their employer contribution under their employer-based group health plan.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- Subscriber or dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2021 SEBB Extended Dependent Certification* and *2021 SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).
- Marriage, registering a state-registered domestic partnership as defined by WAC 182-31-020, birth, adoption, or assuming a legal responsibility for support ahead of adoption. You must also submit a *SEBB Declaration of Tax Status* if adding a SRDP or their child to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

The following events allow a subscriber to enroll dependents.

- Subscriber 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 SEBB Program's annual open enrollment.
- A dependent moves from another country to within the United States, or from the United States to another country, and that change resulted in the dependent losing their health insurance.

The following events allow a subscriber to change medical, dental, or vision plans.

- Subscriber or dependent has a change in residence that affects health plan availability.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicare.
- Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program).
- Subscriber has a change in employment from a SEBB organization to a school district that results in the employee having different medical plans available.

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

4 Medical plan selection

Choose one medical plan.

Kaiser Foundation Health Plan of the Northwest[1]

- Kaiser Permanente NW 1
- Kaiser Permanente NW 2
- Kaiser Permanente NW 3

Kaiser Foundation Health Plan of Washington

- Kaiser Permanente WA Core 1
- Kaiser Permanente WA Core 2
- Kaiser Permanente WA Core 3
- Kaiser Permanente WA SoundChoice[2]

Kaiser Foundation Health Plan of Washington Options, Inc.

- Kaiser Permanente WA Options Access PPO 1
- Kaiser Permanente WA Options Access PPO 2
- Kaiser Permanente WA Options Access PPO 3

Premera Blue Cross

- Premera High PPO
- Premera Peak Care EPO
- Premera Standard PPO

Uniform Medical Plan (UMP), administered by Regence BlueShield

- UMP Achieve 1
- UMP Achieve 2
- UMP High Deductible
- UMP Plus—Puget Sound High Value Network
- UMP Plus—UW Medicine Accountable Care Network

Call the medical plans you are interested in to make sure your provider is in the network. Contact the plans for benefits information. These plans have specific service areas based on the county where you live or work. See HCA's website at **hca.wa.gov/sebb-continuation** for plans available to you. If you move out of the medical plan's service area, you may need to change plans.

2021 SEBB Program medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
1-888-901-4636
TTY: 1-800-833-6388 or 711

Kaiser Foundation Health Plan of Washington Options, Inc.
601 Union St., Suite 3100
Seattle, WA 98101
1-888-901-4636
TTY: 1-800-833-6388 or 711

Premera Blue Cross
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield (for medical benefit questions)
1800 Ninth Avenue, Suite 235
Seattle, WA 98101
1-800-628-3481 TRS: 711

Uniform Medical Plan, administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

1 Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
2 Not all Kaiser Permanente contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before you visit.

Subscriber's last name

Social Security number

5 Dental plan selection

Choose one dental plan. Before you enroll, make sure the provider you want to use accepts the specific plan and group you choose.

Preferred provider organization (PPO)

Uniform Dental Plan (Group #09600), administered by Delta Dental of Washington
You can choose any dental provider and change providers at any time.

Managed-care plans (limited network)

DeltaCare (Group #09601), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to make sure that the provider you want to use accepts this plan.

Willamette Dental of Washington, Inc. (Group WA 733), administered by Willamette Dental Group. You must select a primary care dentist in the Willamette Dental Group Plan. Before you enroll, call Willamette Dental at 1-855-433-6825 to make sure that the provider you want to use accepts this plan.

6 Vision plan selection

Choose one vision plan below. Before you enroll, make sure the provider you want to use accepts the specific plan you choose.

Davis Vision, underwritten by HM Life Insurance Company

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company

MetLife Vision, underwritten by Metropolitan Life Insurance Company

2021 SEBB Program contractors

Do not send forms to the addresses below. This information is only for reference only.

Dental contractors

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-537-3460
TTY: 800-833-6384

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)
TTY: 711

Vision contractors

Davis Vision
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
1-877-377-9353
TTY: 1-800-523-2847

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
1-800-699-0993
TTY: 1-844-230-6498

Metropolitan Life Insurance Company (Vision Plan)
PO Box 385018
Birmingham, AL 35238-5018
1-855-MET-EYE1 (1-855-638-3931)
TTY: 1-800-428-4833

Subscriber's last name

Social Security number

7 Signature

I have received and read the *SEBB Continuation Coverage Election Notice*, including any appendices. By submitting 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 timeline in the SEBB 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 dependents and I may also lose SEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the SEBB Program 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 it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in SEBB insurance coverage. The SEBB Program will verify eligibility for me and my dependents. 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 state-registered domestic partner (SRDP) coverage premium surcharge in addition to my monthly medical premium.

If I enroll in a high-deductible health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the SEBB 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.

I understand that my enrollment and my dependents' enrollment are subject to me abiding by all applicable deadlines and SEBB Program rules and policies. Failure to comply with applicable deadlines and SEBB Program rules and policies may result in my benefits selection being rejected.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted to the SEBB Program.

Subscriber's signature

Date

Please sign, date, and keep a copy for your records. Submit form and documentation using one of the methods below:

Mail to:

Health Care Authority
PO Box 42684
Olympia, WA 98504-2684

Fax to:

360-725-0771

If payment is enclosed, make it payable to Health Care Authority and mail to:

Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Electronically submit:

Send a secure online message to SEBB Customer Service by registering for an account on HCA's website at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

Continue to Section 8 to add or remove dependents.

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

HCA's Privacy Notice: HCA will keep your information private as allowed by law. To see our Privacy Notice, go to HCA's website at **hca.wa.gov/sebb-continuation**.

Subscriber's last name

Social Security number

8 Dependents

List eligible dependents, such as a child defined by WAC 182-31-140, you wish to enroll or remove from coverage. Enrolled children must be eligible under SEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and children age 26 or older with a disability.

If enrolling a state-registered domestic partner's child, extended dependent, or other nonqualified tax dependent, also attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, attach a *SEBB Extended Dependent Certification*, a valid court order showing legal custody or guardianship, and a *SEBB Declaration of Tax Status*.

If enrolling a child with a disability age 26 or older, also attach a *SEBB Certification of Child with a Disability* and return as instructed.

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach a copy of court order)
- Child with a disability age 26 or older

Dependents cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time.

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Continue coverage (Select all that apply.)

Medical Dental Vision

Add coverage (Select all that apply.)

Medical Dental Vision

Terminate coverage (Select all that apply.)

Medical Dental Vision Termination date

If terminating coverage, include reason

1 *This field is required for health care services.*

2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

2021 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Is this person covered by another group medical plan?

Yes No If yes, effective date:

Is this person covered by another group dental plan?

Yes No If yes, effective date:

Is this person covered by another group vision plan?

Yes No If yes, effective date:

Does this person receive Social Security Disability?

Yes No If yes, effective date:

If you answered **Yes** to receiving Social Security Disability, include a copy of your dependent's Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy so we can identify your account. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part A or Part B?

Part A (hospital)

Yes No If Yes, enter effective date shown on the Medicare card:

Part B (medical)

Yes No If Yes, enter effective date shown on the Medicare card:

If you answered **Yes,** proof is required. Include a copy of your dependent's Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account.

Tobacco use premium surcharge

Response required if you are enrolling your dependent age 13 or older in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

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

Yes, I am subject to the $25 premium surcharge. This person has used tobacco products in the past two months. If this is a change to a previous attestation, submit the *SEBB Premium Surcharge Attestation Change Form*.

No, I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

If adding two or more dependents, copy pages 13 – 14 and attach to this form.