Clear form

COBRA Subsidy Election for SEBB Continuation Coverage

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

The American Rescue Plan Act (ARPA) of 2021 provides a 100-percent subsidy of COBRA monthly premiums for certain eligible individuals from April 1 through September 30, 2021. If you're eligible, your monthly premiums and any applicable premium surcharges for SEBB Continuation Coverage (COBRA or Unpaid Leave) for yourself and any eligible dependents would be fully covered from April 1 through September 30, unless you or your dependents lose eligibility. You would lose eligibility for the subsidy if you gain eligibility for other group coverage, such as an employer or spouse's health coverage, or become eligible for Medicare.

The subsidy applies to eligible spouses, state-registered domestic partners, and dependent children who were enrolled on your employer-paid SEBB health benefits at the time you lost coverage. Please see **hca.wa.gov/sebb-continuation** for more information on eligibility for COBRA and Unpaid Leave.

Eligibility for the subsidy

To be eligible for the subsidy you must:

- Have lost eligibility for employer-paid health benefits due to a reduction of hours or involuntary termination.
- Not be eligible for other group health insurance or Medicare.
- Be currently eligible for SEBB Continuation Coverage
  OR
  Be newly eligible for SEBB Continuation Coverage between April 1 and September 1, 2021.

Please check which of these describes you:

☐ I was eligible for SEBB Continuation Coverage on or after November 1, 2019, and am still eligible for SEBB Continuation Coverage on April 1, 2021.

☐ I am newly eligible for SEBB Continuation Coverage between April 1 and September 30, 2021.

Important financial effects

- If you become eligible for other group health plan coverage or Medicare while you are receiving the subsidy — even if you do not enrol in them — or you enroll in a Health Coverage Tax Credit (HCTC), you must submit a *Notice of Expiration of Premium Assistance* form to the SEBB Program. If you do not, you may be subject to a $250 tax penalty. The form is available on the HCA website at **hca.wa.gov/cobra-subsidy**.
- If you became eligible for continuation coverage between November 1, 2019 and April 1, 2021, and you are eligible for the subsidy, you can choose to enroll either a) back to your original eligibility date or b) beginning on April 1, 2021. The subsidy, however, applies only from April 1 to September 30, 2021. You must pay for premiums and applicable premium surcharges for coverage before or after the subsidy period.
- Receiving the subsidy disqualifies you for the Health Coverage Tax Credit (HCTC) on your 2021 income taxes.
- You cannot qualify for a premium tax credit to help pay for coverage through the Health Insurance Marketplace for any months that you are enrolled in SEBB Continuation Coverage, with or without the subsidy.
- If your federal continuation coverage eligibility ends before September 30, 2021, your premium subsidy ends at the same time. You may be able to continue your enrollment in SEBB Continuation Coverage, but you will need to pay your premiums and applicable premium surcharges.
- If you are still eligible for SEBB Continuation Coverage after September 30, 2021, you will stay enrolled, unless you notify the SEBB Program in writing to terminate your coverage. The notice must include the last four digits of your Social Security number on the correspondence so we can identify your account. See the *SEBB Continuation Coverage Election Notice*, available on the HCA website at **hca.wa.gov/erb** under *Forms & Publications*, for more information on how and where to send your termination notice. If you do not terminate your coverage, you will be charged the monthly premiums and applicable premium surcharges, starting October 1, 2021. If you terminate, your SEBB Continuation Coverage will end on the last day of the month in which the SEBB Program receives your written notice. If your written notice is received on the first day of the month, coverage will end on the last day of the previous month. You will not be eligible to enroll again unless you regain eligibility for SEBB Continuation Coverage.

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

Instructions

We must receive this form and the *Request for Treatment as an Assistance Eligible Individual* form **no later than 60 days** from the date on the enclosed letter. The *SEBB Continuation Coverage Election Notice* booklet explains the rules and eligibility for COBRA and Unpaid Leave coverage. Do not return the *SEBB Continuation Coverage Enrollment/Change* form that is in the booklet.

You may need to include additional forms if you are enrolling a spouse, state-registered domestic partner, child up to age 26, extended dependent, or dependent with a disability. Submit those required forms with this form.

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

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in dark ink and use all capital lettering in the spaces provided. Example: J O H N . This form replaces all *SEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* forms previously submitted.

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

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

Date you request coverage to begin, if eligible before April 1, 2021.
See initial eligibility letter for details.

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****.*

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

Is other coverage available for you?

Are you eligible for SEBB health coverage under another account?

☐ Yes ☐ No

Are you eligible for another group medical plan?

☐ Yes ☐ No If yes, effective date

Are you eligible for Medicare?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to any of the three questions above, you are **not eligible** for the medical premium subsidy. To enroll in SEBB Continuation Coverage without the subsidy, please submit the *SEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* form.

If you have SEBB life insurance you 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.

Are you eligible for another group dental plan?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to the question above, you are **not eligible** for the dental premium subsidy. You may still be eligible for the medical or vision subsidy if you are not enrolled in other group medical or vision coverage or Medicare. To enroll in SEBB Continuation Coverage for dental only without the subsidy, please submit a *SEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* form.

Are you eligible for another group vision plan?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to the question above, you are **not eligible** for the vision premium subsidy. You may still be eligible for the medical or dental subsidy if you are not enrolled in other group medical or dental coverage or Medicare. To enroll in SEBB Continuation Coverage for vision only without the subsidy, please submit a *SEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* form.

Do you receive Social Security Disability?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to receiving Social Security Disability, you must send 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 a health flexible spending arrangement (FSA)?

☐ Yes ☐ No If yes, effective date

Choose the kind of coverage you want. (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

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 the *SEBB Continuation Coverage (COBRA) or (Unpaid Leave) Election/Change* form, sending a written request to the address listed on page 11, or calling 1-800-200-1004 (TRS: 711).

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

Tobacco use premium surcharge

A response is 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 you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge. **If you are eligible for the subsidy, you will not pay this surcharge while the subsidy applies. You must answer the questions below, regardless of whether the subsidy applies to you.**

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**.

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.

☐ **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*.

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) you wish to cover. They must have been enrolled on your employer-paid SEBB health benefits at the time you lost coverage, as defined by Washington Administrative Code 182-31-020. Your spouse or SRDP cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time. To enroll children, please complete Section 8 at the end of this form.

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

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****.*

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

Is other coverage available for your spouse or SRDP?

Is this person eligible for SEBB health coverage under another account?

☐ Yes ☐ No

Is this person eligible for another group medical plan?

☐ Yes ☐ No If yes, effective date

Is this person eligible for Medicare?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to any of the three questions above, this person is **not eligible** for the medical premium subsidy. You may include this person on your SEBB Continuation Coverage, but you will have to pay the premiums and applicable premium surcharges.

Is this person eligible for another group dental plan?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to the question above, this person is **not eligible** for the dental premium subsidy. They may still be eligible for the medical or vision subsidy if they are not enrolled in other group medical or vision coverage. You may include this person on your SEBB Continuation Coverage, but you will have to pay the premiums and applicable premium surcharges.

Are you eligible for another group vision plan?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to the question above, this person is **not eligible** for the vision premium subsidy. They may still be eligible for the medical or dental subsidy if they are not enrolled in other group medical or dental coverage or Medicare. You may include this person on your SEBB Continuation Coverage, but you will have to pay the vision premiums and applicable premium surcharges.

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 spouse's or state-registered domestic partner'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.

Choose the kind of coverage you want. (Select all that apply)

☐ Medical ☐ Dental ☐ Vision

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

Tobacco use premium surcharge

A response is required if you are 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 premium. **If you are eligible for the subsidy, you will not pay this surcharge while the subsidy applies. You must answer the questions below, regardless of whether the subsidy applies to you.**

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 this person has enrolled in the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

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

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

If you check **Yes** or do not check any boxes below, you will be charged the $50 spouse or SRDP coverage premium surcharge. If this premium surcharge applies to you, this person is **not eligible** for the COBRA subsidy. You may include this person on your SEBB Continuation Coverage, but you will have to pay the premiums and applicable premium surcharges. **You must answer the questions below, regardless of whether the subsidy applies to you.**

Does the spouse or state-registered domestic partner coverage premium 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*.
- **No**, I am not subject to the $50 premium surcharge. I used the *SEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *2021 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 will help determine if premium surcharge applies. I used the *SEBB Premium Surcharge Attestation Help Sheet* and am 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 *2021 SEBB Spousal Plan Calculator* are available on HCA's website at **hca.wa.gov/sebb-continuation** under ***Forms & publications***.

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

3 Medical plan selection

You may choose the same medical plan you had as an employee, or you may change plans.

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 with an HSA[3]
- ☐ UMP Plus—Puget Sound High Value Network
- ☐ UMP Plus—UW Medicine Accountable Care Network

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)

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.

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.*
3 *If you enroll in UMP High Deductible with an HSA, you will not receive employer contributions to an HSA during the period in which you are receiving the subsidy. You can find information on the HCA website at hca.wa.gov/cobra-subsidy. If you have additional questions, call the SEBB Program at 1-800-200-1004 (TRS: 711).*

Subscriber's last name

Social Security number

4 Dental plan selection

Choose one dental plan. You may choose the same dental plan you had as an employee, or you may change plans. Before you enroll, make sure the provider you want to use accepts the specific plan 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.

5 Vision plan selection

Choose one vision plan. You may choose the same vision plan you had as an employee, or you may change plans. 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 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

6 Unpaid Leave

Fill out Section 6 only if you are applying for SEBB Continuation Coverage (Unpaid Leave).

What is the qualifying event that allows you to apply for Unpaid Leave? Check only one.

- ☐ Applying for disability retirement
- ☐ Layoff
- ☐ Approved Leave Without Pay (LWOP)
- ☐ Worker's compensation
- ☐ Employee appealing a grievance
- ☐ USERRA (military) leave Date called to duty in the uniformed services

Life and accidental death and dismemberment (AD&D) insurance (Unpaid Leave only)

You may choose to continue your life insurance and AD&D insurance while on SEBB Continuation Coverage (Unpaid Leave) by self-paying the premiums. See the HCA website at **hca.wa.gov/sebb-continuation** for details. If you have life insurance and wish to decrease, port, convert, or terminate coverage, call MetLife at 1-833-854-9624.

Choose one:

- ☐ **Yes**, I wish to continue the life and AD&D insurance I had as an employee. I understand I will need to pay MetLife directly for basic life insurance and basic AD&D insurance in addition to any supplemental life and AD&D insurance I have while on SEBB Continuation Coverage (Unpaid Leave).

- ☐ **No**, I do not wish to continue the life and AD&D insurance I had as an employee. I understand I must reapply for supplemental life insurance and AD&D insurance when I regain eligibility and I must submit evidence of insurability to MetLife for supplemental life insurance. I understand that MetLife must receive my *MetLife Enrollment/Change Form* through MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb** **no later than 31 days** from the date I regain eligibility.

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

7 Signature

I have received and read the *SEBB Continuation Coverage Election Notice*, including 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 timelines in SEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s). 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 fully 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 SEBB benefits.

The SEBB Program will verify eligibility for my dependents and me. I acknowledge that I am responsible for paying for premiums and any applicable premium surcharges for myself and my enrolled dependents before or after the subsidy period, April 1, 2021 to September 30, 2021, or for any ineligible dependents during the subsidy period. I understand that if I am enrolled after September 30, 2021 I will be invoiced for premiums and applicable premium surcharges for coverage beginning October 1, 2021. I understand that if I or my dependents lose eligibility for the subsidy before September 30, 2021, I must submit the *Notice of Expiration of Premium Assistance* form to terminate the subsidy.

If I am enrolling in UMP High Deductible 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, except during the period I am receiving the premium subsidy, 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 if I enroll in UMP High Deductible, I will not receive employer contributions to an HSA while receiving the premium subsidy.

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 or Unpaid Leave) 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 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**.

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

8 Dependents

List eligible dependents you wish to enroll in coverage. Enrolled children must be eligible under SEBB Program rules and must have been enrolled on your employer-paid SEBB benefits at the time you lost coverage. 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. Dependents cannot be enrolled in two SEBB medical or dental accounts at the same time.

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*.

Relationship to subscriber

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

If adding two or more dependents, copy pages 12 and 13 and submit with this form.

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

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****.*

COBRA Subsidy Election Form for SEBB Continuation Coverage

Subscriber's last name

Social Security number

Is other coverage available for your dependent?

Is this person eligible for SEBB health coverage under another account?

☐ Yes ☐ No

Is this person eligible for another group medical plan?

☐ Yes ☐ No If yes, effective date

Is this person eligible for Medicare?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to any of the three questions above, this person is **not eligible** for the subsidy. You may include this person on your SEBB Continuation Coverage, but you will have to pay the premiums and applicable premium surcharges.

Is this person eligible for another group dental plan?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to the question above, this person is **not eligible** for the dental subsidy. They may still be eligible for the medical or vision subsidy if they are not enrolled in other group medical or vision coverage. You may include this person on your SEBB Continuation Coverage, but you will have to pay the premiums and applicable premium surcharges.

Is this person eligible for another group vision plan?

☐ Yes ☐ No If yes, effective date

If you answered **Yes** to the question above, this person is **not eligible** for the vision subsidy. They may still be eligible for the medical or dental subsidy if they are not enrolled in other group medical or dental coverage. You may include this person on your SEBB Continuation Coverage, but you will have to pay the premiums and applicable premium surcharges.

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.

Choose the kind of coverage you want. (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Tobacco use premium surcharge

A response is required for dependents age 13 or older enrolling 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 premium. **If you are eligible for the subsidy, you will not pay the premium surcharge while the subsidy applies. You must answer the questions about the tobacco premium surcharge, regardless of whether the subsidy applies to you.**

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

☐ **Yes,** I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.

☐ **No,** I am not subject to the $25 premium surcharge. This dependent 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*.