Health Care Authority
School Employees Benefits Board

# 2026 SEBB School Board Member Election/Change Form

Use this form to enroll in SEBB School Board Member coverage.

We must receive this form and other required documents **no later than 60 days** from the beginning of your elected or appointed term.

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.

Your SEBB health plan coverage will begin the first day of the month following the day we receive the required forms.

This form replaces all *School Board Member Election/Change* forms previously submitted. You must complete the entire form, including the dependent section for any children you want to cover.

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

All forms and documents are available at **hca.wa.gov/employee-retiree-benefits/school-board-members-sebb** under *Forms & publications*, or by calling 1-800-200-1004 (TRS: 711).

⚠ Remember to read and sign Section 8.

## 1 Subscriber

What district are you a board member of?

What are the dates of your board term?

to

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

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

[2] *This field is not required for enrollment. Your response is optional and will be kept private to the extend allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

⚠ 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, sending a written request by mail or secure message (see "Form return" on page 12), or calling 1-800-200-1004 (TRS: 711).

Are you or any eligible dependents already enrolled in SEBB insurance coverage under another account?

☐ Yes ☐ No

**Enroll in coverage**

☐ You will be enrolled in SEBB medical, dental, and vision.

**Terminate coverage**

☐ Your enrollment in SEBB medical, dental, and vision will be terminated.

Termination date:

If terminating coverage, include reason:

⚠ If you terminate coverage prior to the end of your elected term, you will not be eligible to enroll again in SEBB health plan coverage as a school board member unless you regain eligibility.

## 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 an enrolled dependent (age 13 or older) 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. Visit HCA's website at **hca.wa.gov/sebb-continuation** for more information.

If you check Yes or leave this section blank, you will be charged the $25 premium surcharge.
If this is a change to a previous attestation, submit the *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 or accessed one of the tobacco cessation resources.

Subscriber's last name

Social Security number

## 2 Spouse or state-registered domestic partner (SRDP)

**If enrolling or removing a spouse or SRDP, complete this section.** If not, skip to the next section.

List your spouse or SRDP you wish to cover or remove from coverage. SRDP is defined in WAC 182-31-020. State-registered domestic partnerships include partners of legal unions from another jurisdiction that is substantially equivalent to a domestic partnership in Washington State. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law.

You must provide proof of their eligibility within the SEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of accepted documents are available on HCA's website at **hca.wa.gov/sebb-continuation**.

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

If enrolling an SRDP, attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

**Relationship to subscriber**.

☐ **Spouse:** Date of marriage

☐ **SRDP (Washington State):** Partnership start date

☐ **SRDP (legal union):** Start date

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

**Enroll in coverage**

☐ Your spouse/SRDP will be enrolled in SEBB medical, dental, and vision.

**Terminate coverage**

☐ Your spouse/SRDP's enrollment in SEBB medical, dental, and vision will be terminated.

Termination date:

If terminating coverage, include reason:

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

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

[2] *This field is not required for enrollment. Your response is optional and will be kept private to the extend allowable by law. Gender X means a gender that is not exclusively male nor female.. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

## Tobacco use premium surcharge

Response 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 tobacco use premium surcharge in addition to your monthly premium. See page 2 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.

☐ **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.

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

Response required if you are enrolling your spouse or SRDP in medical coverage. The SEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you enroll your spouse or SRDP in SEBB medical and they have chosen not to enroll in another employer-based group medical insurance that is comparable to the Public Employee Benefits Board (PEBB) Program's Uniform Medical Plan (UMP) Classic.

**Answer these questions for your spouse or SRDP in 2026:**

1. Are you covering your spouse or SRDP in a SEBB medical plan under your account?
   ☐ Yes ☐ No
2. Will they be eligible for medical coverage through their employer? (If they will not be employed, answer No.)
   ☐ Yes ☐ No
3. Will their employer offer at least one medical plan that serves their county of residence?
   ☐ Yes ☐ No
4. Have they chosen not to enroll in their employer's medical coverage?
   ☐ Yes ☐ No
5. Will the coverage offered by their employer **not** be through the SEBB or PEBB Program or a TRICARE plan?
   - Answer Yes if their employer **does not** offer SEBB or PEBB coverage or a TRICARE plan.
   - Answer No if their employer **offers** SEBB or PEBB coverage or a TRICARE plan.

   ☐ Yes ☐ No
6. Will their share of the medical premium through their employer be less than $137.76 per month?
   ☐ Yes ☐ No

If you answered No to any of these questions, check No below. You will not be charged the surcharge.
If you answered Yes to all of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:
   a. Serve their county of residence.
   b. Have a monthly premium of less than $137.76 per month for the employee.
2. Use the SBC information to answer the questions in the *SEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response below.

⚠ The *SEBB Spousal Plan Calculator* is available at **hca.wa.gov/sebb-employee** under *Surcharges*.

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

☐ **Yes**, I am subject to the $50 premium surcharge. I completed the *SEBB Spousal Plan Calculator*.

☐ **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *SEBB Spousal Plan Calculator*.

☐ I need the SEBB Program to determine if the premium surcharge applies. I am submitting a printed *SEBB Spousal Plan Calculator*.

⚠ If you check Yes or leave this section blank, you will be charged the monthly $50 premium surcharge.

Subscriber's last name

Social Security number

## 3 Dependents

**If enrolling or removing a dependent, complete this section.** If not, skip to the next section.

List dependents you wish to add or remove from coverage. They 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.

You must provide proof of their eligibility within the SEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of accepted documents are available on HCA's website at **hca.wa.gov/sebb-continuation**.

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

If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

If enrolling an extended dependent, attach a *SEBB Extended Dependent Certification*.

If enrolling a child with a disability age 26 or older, attach a *SEBB Certification of a Child with a Disability*.

⚠ **If adding more dependents, copy the dependents section and attach to this form.**

**Relationship to subscriber**

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

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] *This field is not required for enrollment. Your response is optional and will be kept private to the extend allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

**Enroll in coverage**

☐ Your dependent will be enrolled in SEBB medical, dental, and vision.

**Terminate coverage**

☐ Your dependent's enrollment in medical, dental, and vision will be terminated.

Termination date:

If terminating coverage, include reason:

### Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 and 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. See page 2 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 dependent has used tobacco products in the past two monthss.

☐ **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.

Subscriber's last name

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## 4 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, go to to Section 5.

### Changes you can make anytime

☐ Name change

☐ Address change

### Changes you can make during annual open enrollment

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

☐ Add dependents

☐ Remove dependents

☐ Change medical plan

☐ Change dental plan

☐ Change vision plan

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

The SEBB Program only allows changes outside of annual open enrollment when an event creates an SOE. The change must be allowed under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with an SOE event for the subscriber, a dependent, or both. 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, we must receive the required forms **no later than 60 days** after the date of the birth or 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 we receive the form, whichever is later.

**Note:** A health plan change is not allowed when adding an SRDP or their child if they are not a tax dependent.

## Check the box next to the applicable special open enrollment events below.

**The following events allow a subscriber to add 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 or their 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 *SEBB Extended Dependent Certification* and *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes, available at **hca.wa.gov/sebb-continuation**.
- Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. You must also submit a *SEBB Declaration of Tax Status* if adding a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes.

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Subscriber's last name

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**The following events allow a subscriber to add 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.
- Subscriber's 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.
- Subscriber's dependent loses eligibility for Medicare.

**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. **Note:** If the subscriber's current dental plan does not have available providers within 50 miles of the subscriber's or the dependent's new residence, the subscriber may select a new dental plan.
- Subscriber or dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the SEBB Program).
- Subscriber's or dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.

Subscriber's last name

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## 5 Medical plan selection

**Choose one medical plan.** You can find information about medical plan options on HCA's website at **hca.wa.gov/sebb-continuation**. Contact the plans with questions about benefits and providers. Before you enroll, make sure the provider you want to use accepts the specific plan you choose. Contact information at the end of this form.

**Kaiser Foundation Health Plan of the Northwest[1] (Kaiser Permanente NW)**

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

**Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)**

- ☐ Kaiser Permanente WA Core 1
- ☐ Kaiser Permanente WA Core 2
- ☐ Kaiser Permanente WA Core 3
- ☐ Kaiser Permanente WA SoundChoice

**Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente WA Options)**

- ☐ Kaiser Permanente WA Options Summit PPO 1
- ☐ Kaiser Permanente WA Options Summit PPO 2
- ☐ Kaiser Permanente WA Options Summit PPO 3

**Premera Blue Cross**

- ☐ Premera High PPO
- ☐ Premera HMO
- ☐ Premera Standard PPO

**Uniform Medical Plan, administered by Regence BlueShield and ArrayRx**

- ☐ UMP Achieve 1
- ☐ UMP Achieve 2
- ☐ UMP High Deductible

⚠ These plans have specific service areas. All School Board members will be offered a choice of plans based on their county of residence or the county the school district or educational service district they represent is located. If the district that you represent crosses county lines, you should identify all counties in which your school district is located to see all plan options available to you. See HCA's website at **hca.wa.gov/sebb-continuation** for available plans.

If you move out of the service area or change employment location, and your current medical plan is no longer available, you must select a new plan. If you do not, the SEBB Program will enroll you in a plan. You must report your new address to the SEBB Program and request a plan change **no later than 60 days** after you move. You can use this form, send a written request by mail or secure message (see "Form return" on page 12), or call 1-800-200-1004 (TRS: 711).

1. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

Subscriber's last name

Social Security number

## 6 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. Your out-of-pocket costs will be lower if you use a preferred provider.

**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.
- **Willamette Dental of Washington** (Group WA 733), administered by Willamette Dental of Washington, Inc. You must select and receive care from a primary care dental provider in the Willamette Dental network.

## 7 Vision plan selection

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

- **Davis Vision by MetLife**, underwritten by Metropolitan Life Insurance Company ("MetLife")
- **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
- **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

⚠ Plan contact information is at the end of this form.

Subscriber's last name

Social Security number

## 8 Signature

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 the SEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans or premiums paid on my behalf. My dependents and I may also lose SEBB health plan coverage 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 SEBB insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in SEBB health plan 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.

I understand if I enroll in SEBB dental or vision, it is my responsibility to call the plan (not my provider) to verify my provider is covered by the dental plan network and vision plan network I selected.

If I enroll in UMP High Deductible, I must meet health savings account (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 *School Board Member Election/Change* forms previously submitted to the SEBB Program.

### Sign, date, and keep a copy for your records.

Subscriber's signature

Date

### Form return

Submit form and documentation using one of the methods below:

**Mail to:**

Washington State Health Care Authority
PO Box 42720
Olympia, WA 98504-2720

**Fax to:**

360-725-0771

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

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

**Secure message:**

Send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call 1-800-200-1004 (TRS: 711) or visit **hca.wa.gov/about-hca/nondiscrimination-statement**.

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

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Social Security number

## SEBB Program contractors

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

### Medical

**Kaiser Foundation Health Plan of the Northwest**
500 NE Multnomah St.,
Suite 100
Portland, OR 97232-5398
1-800-813-2000 (TRS: 711)

**Kaiser Foundation Health Plan of Washington**
2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

**Kaiser Foundation Health Plan of Washington Options, Inc.**
2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

**Premera Blue Cross**
High PPO and Standard PPO
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310 (TRS: 711)

**Premera Blue Cross HMO**
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310 (TRS: 711)

**Uniform Medical Plan,** administered by Regence BlueShield (for medical benefits)
PO Box 1106
Lewiston, ID 83501-1106
1-800-628-3481 (TRS: 711)

**Uniform Medical Plan**, administered by ArrayRx (for prescription drug benefits)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

### Dental

**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
1-800-537-3406
TTY: 1-800-833-6384

**Willamette Dental of Washington, Inc.**
910 NE 82nd St.
Vancouver, WA 98665
1-855-433-6825 (TRS: 711)

### Vision

**Davis Vision by MetLife,** underwritten by Metropolitan Life Insurance Company
200 Park Ave.
New York, NY 10166
1-877-377-9353
TTY: 1-800-523-2847

**EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
4000 Luxottica Place
Mason, OH 45040
1-800-699-0993
TTY: 1-844-230-6498

**Metropolitan Life Insurance Company** (Vision Plan)
200 Park Ave.
New York, NY 10166
1-833-854-9624
TTY: 1-800-428-4833