COBRA Subsidy Election Form for PEBB Continuation Coverage

Washington State Health Care Authority
PUBLIC 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 PEBB 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 PEBB health benefits at the time you lost coverage. Please see **hca.wa.gov/pebb-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 PEBB Continuation Coverage or PEBB retiree insurance coverage

  OR

  Be newly eligible for PEBB Continuation Coverage or PEBB retiree insurance between April 1 and September 1, 2021.

Please check which of these describes you:

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

☐ I am newly eligible for PEBB Continuation Coverage or retiree insurance 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 enroll 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 PEBB 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 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 PEBB 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 PEBB Continuation Coverage, but you will need to pay your premiums and applicable premium surcharges.
- If you are still eligible for PEBB Continuation Coverage after September 30, 2021, you will stay enrolled, unless you notify the PEBB 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 *PEBB 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 PEBB Continuation Coverage will end on the last day of the month in which the PEBB 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 PEBB Continuation Coverage.

COBRA Subsidy Election Form for PEBB 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 *PEBB Continuation Coverage Election Notice* booklet explains the rules and eligibility for COBRA and Unpaid Leave coverage. Do not return the *PEBB 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 *PEBB Continuation Coverage Election Notice,* are available on HCA's website at **hca.wa.gov/pebb-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 *PEBB 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 PEBB Continuation Coverage

Subscriber's last name

Social Security number

Is other coverage available for you?

Are you eligible for PEBB 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 PEBB Continuation Coverage without the subsidy, please submit the *PEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* form.

If you have PEBB life insurance you wish to port or convert, call MetLife at 1-866-548-7139. 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 PEBB 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 subsidy if you are not enrolled in other group medical coverage or Medicare. To enroll in PEBB Continuation Coverage for dental only without the subsidy, please submit a *PEBB 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

Tobacco use premium surcharge

A response is required if you are enrolling in medical coverage. The PEBB 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 PEBB 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 on the next page, 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, 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 PEBB Program Administrative Policy 91-1 at **hca.wa.gov/pebb-rules**.

See the *2021 PEBB Premium Surcharge Attestation Help Sheet,* available on HCA's website at **hca.wa.gov/pebb-continuation** for instructions on how to respond. To change your attestation, use the *2021 PEBB Premium Surcharge Attestation Change Form*.

Subscriber's last name

Social Security number

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 one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*.

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 PEBB health benefits at the time you lost coverage, as defined by Washington Administrative Code 182-12-109. Your spouse or SRDP cannot be enrolled in two PEBB medical or dental accounts at the same time. To enroll children, please complete Section 7 at the end of this form.

Relationship to subscriber

☐ Spouse: date of marriage

☐ SRDP: date registered

If enrolling a SRDP, attach a *2021 PEBB 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 also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. A list of documents we will accept to verify eligibility is available on HCA's website at **hca.wa.gov/pebb-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)

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 PEBB Continuation Coverage

Subscriber's last name

Social Security number

Is other coverage available for your spouse or SRDP?

Is this person eligible for PEBB 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 PEBB 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 subsidy if they are not enrolled in other group medical coverage. You may include this person on your PEBB 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 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

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.

☐ **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 *PEBB Premium Surcharge Attestation Help Sheet*.

COBRA Subsidy Election Form for PEBB Continuation Coverage

Subscriber's last name

Social Security number

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 PEBB Program requires a monthly $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in PEBB medical and this person has chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic. See the *2021 PEBB 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 PEBB 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 *PEBB Premium Surcharge Attestation Help Sheet* and completed the 2021 *PEBB Spousal Plan Calculator*.

☐ **No,** I am not subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the 2021 *PEBB Spousal Plan Calculator*. Which questions, if any, on the *PEBB 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 PEBB Program will help determine if the premium surcharge applies. I used the *PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *PEBB Spousal Plan Calculator*. The PEBB Program will use these to help determine whether my spouse's or SRDP's employer-based group medical is comparable to UMP Classic and whether I am subject to the premium surcharge.

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

Subscriber's last name

Social Security number

3 Medical plan selection

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

Contact the plans with questions about benefits and providers. Their contact information is on page 8.

If you move out of the medical plan's service area, you may need to change plans. You must report your new address to the PEBB Program **no later than 60 days** after you move by using a *PEBB 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).

Kaiser Foundation Health Plan of the Northwest[1,2]

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2,4]

Kaiser Foundation Health Plan of Washington[1]

- ☐ Kaiser Permanente WA Classic
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[4]
- ☐ Kaiser Permanente WA SoundChoice[3]
- ☐ Kaiser Permanente WA Value

Uniform Medical Plan (UMP), administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Select
- ☐ UMP Consumer-Directed Health Plan[4]
- ☐ UMP Plus—Puget Sound High Value Network[1]
- ☐ UMP Plus—UW Medicine Accountable Care Network[1]

1. These plans have specific service areas. If you move out of the service area, you must change your plan. Otherwise, you will have limited access to network providers and covered services. You must notify the PEBB Program **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
3. Not all Kaiser Permanente contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.
4. If you enroll in a CDHP, 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**.
5. If you have additional questions, call the PEBB 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 plans 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 #03000), 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 #03100), 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 verify your provider accepts the specific plan network and plan group.

Willamette Dental of Washington, Inc. (Group WA82), administered by Willamette Dental Group. You will select and receive care from a primary care dentist in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

2021 PEBB Program contractors

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

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 98101-1374
1-866-648-1928 (TTY: 1-800-833-6388)

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Avenue
Suite 235
Seattle, WA 98101
1-888-849-3681 (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)

Dental Contractors

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

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview Ave. N.
Suite 800
Seattle, WA 98109-5371
1-800-537-3406

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

Subscriber's last name

Social Security number

5 Unpaid Leave

Fill out Section 5 only if you are applying for PEBB 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
- ☐ Reversion employee (for reasons other than a layoff)
- ☐ Approved Leave Without Pay (LWOP)
- ☐ Workers' compensation
- ☐ Approved educational leave
- ☐ Faculty between periods of eligibility
- ☐ Seasonal employee off-season
- ☐ Employee appealing a dismissal action
- ☐ 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 PEBB Continuation Coverage (Unpaid Leave) by self-paying the premiums. See the HCA website at **hca.wa.gov/pebb-continuation** for details. To terminate life or AD&D insurance, or decrease your insurance amounts, call MetLife at 1-866-548-7139.

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 for basic life insurance and basic AD&D Insurance in addition to any supplemental life and AD&D insurance I have while on PEBB 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 online portal at mybenefits.metlife.com/wapebb **no later than 31 days** after the date I regain eligibility.

Subscriber's last name

Social Security number

Long-term disability (LTD) insurance (Unpaid Leave only)

This applies only to employees on approved educational leave, or who are called to active duty in the uniformed services as defined under Uniformed Services Employment and Reemployment Rights Act (USERRA). If you belong to either group, you may choose to self-pay basic and supplemental long-term disability (LTD) coverage while on PEBB Continuation Coverage (Unpaid Leave). See the HCA website at **hca.wa.gov/pebb-continuation** for details.

What is your current enrollment with your employing agency?

- ☐ Basic LTD coverage ($2.10/month)
- ☐ Supplemental LTD coverage (Select your current waiting period.)
  - ☐ 90-day
  - ☐ 180-day
  - ☐ 300-day
  - ☐ 120-day
  - ☐ 240-day
  - ☐ 360-day

Desired enrollment while self-paying

- ☐ I wish to keep the same basic LTD insurance I had as an employee, and increase the supplemental LTD insurance waiting period. I understand I must reapply for the lower waiting period under supplemental LTD insurance and submit evidence of insurability to The Standard for approval when I regain eligibility for the employer contribution. I understand my employing agency must receive the required enrollment forms **no later than 31 days** after the date I regain eligibility.

  Initial

- ☐ I do not wish to keep the LTD insurance I had as an employee. I understand I must reapply for the supplemental LTD insurance and submit evidence of insurability to The Standard for approval when I regain eligibility for the employer contribution. I understand my employing agency must receive the required enrollment forms **no later than 31 days** after the date I regain eligibility.

  Initial

- ☐ I wish to keep the same coverage I had as an employee.

  Initial

Subscriber's last name

Social Security number

6 Signature

I have received and read the *PEBB 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 PEBB 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 PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB 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 PEBB benefits.

The PEBB 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 a consumer-directed health plan (CDHP) 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, 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 a CDHP, 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 PEBB Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my benefits selection being rejected. This form replaces all *PEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* forms previously submitted to the PEBB 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 PEBB 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 7 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 PEBB 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 **hca.wa.gov/pebb-continuation**.

Subscriber's last name

Social Security number

7 Dependents

List eligible dependents you wish to enroll in coverage. Enrolled children must be eligible under PEBB Program rules and must have been enrolled on your employer-paid PEBB 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 PEBB 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 *PEBB Declaration of Tax Status* to indicate whether the child qualifies as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, attach a *PEBB Extended Dependent Certification*, a valid court order showing legal custody or guardianship, and a *PEBB 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 PEBB Continuation Coverage

Subscriber's last name

Social Security number

Is other coverage available for your dependent?

Is this person eligible for PEBB 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 PEBB 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 subsidy if they are not enrolled in other medical coverage. You may include this person on your PEBB 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 coverage. (Select all that apply.)

☐ Medical ☐ Dental

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 *2021 PEBB Premium Surcharge Attestation Help Sheet*.