CLEAR FORM

Notice of expiration of premium assistance

Washington State Health Care Authority

Use this form to notify the PEBB Program or SEBB Program that you are eligible for another group health coverage or Medicare, and therefore no longer eligible for the COBRA subsidy under the American Rescue Plan Act of 2021. You must report eligibility for other coverage or Medicare, regardless of whether you or a dependent on your account enroll in it..

For most subscribers, this does not terminate your COBRA coverage. This will only end your COBRA subsidy. If you wish to terminate your COBRA coverage, send a written notice to the address at the end of this form. For SEBB subscribers only: If you are eligible for Medicare, you are no longer eligible for COBRA, and this form will serve as notice to terminate your SEBB Continuation Coverage (COBRA).

1 Subscriber

Social Security number

Date of birth (mm/dd/yyyy)

Program (Check one.)

☐ PEBB ☐ SEBB

Last name

First name

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

2 Information about other coverage

Please check the event (below and on the next page) that makes you ineligible for the COBRA subsidy.

☐ **I am eligible for coverage under another group health plan.**

Date you became eligible for other coverage (mm/dd/yyyy)

If any dependents are also eligible for other coverage, include their names. If additional space needed, copy this form and attach.

Dependent 1 last name

First name

Date they became eligible for other coverage (mm/dd/yyyy)

Dependent 2 last name

First name

Date they became eligible for other coverage (mm/dd/yyyy)

☐ **I am eligible for Medicare.**

Date you became eligible for Medicare (mm/dd/yyyy)

If any dependents are also eligible for Medicare, include their names.

Dependent 1 last name

First name

Date they became eligible for Medicare (mm/dd/yyyy)

Dependent 2 last name

First name

Date they became eligible for Medicare (mm/dd/yyyy)

Important

If you fail to notify us when you or your covered dependents become eligible for another group health coverage or Medicare, and you or your dependents continue to receive the COBRA premium subsidy, you or your dependents may be subject to a tax penalty of $250. If the failure is fraudulent, the penalty is the greater of $250 or 110 percent of the amount of the premium assistance provided after termination of eligibility. You will not be subject to the penalty if the failure to notify the plan is due to reasonable cause and not due to willful neglect. Eligibility for other coverage is determined regardless of whether you take or decline the other coverage. However, eligibility for other coverage does not include any time spent in a waiting period.

3 Signature

To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Subscriber's signature

Date (mm/dd/yyyy)

Print name

Mail to:

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

Fax to:

360-725-0771

Electronically submit:

Send a secure online message to 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.

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 or 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 **hca.wa.gov/pebb-continuation**.