

2026 PEBB Continuation Coverage (COBRA/Employer Group Ended Participation) Election/Change

Use this form if any of the following applies:

- You are a public employee who lost your PEBB health plan coverage due to a qualifying event and want to continue it under federal COBRA coverage.
- You are a retired public or school employee of an employer group and you lost eligibility for PEBB retiree insurance coverage due to your employer group ending participation in Public Employee Benefits Board (PEBB) or School Employee Benefits Board (SEBB) insurance coverage.

We must receive this form **no later than 60 days** from:

- The date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.
- The date your employer group ended their participation in PEBB Program benefits.

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

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

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

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



Remember to read and sign Section 8.

Employee or retiree (subscriber) information only

COBRA subscribers: If you are a spouse, state-registered domestic partner, or dependent who is enrolling in coverage for yourself, provide the employee or retiree subscriber here. You will provide your information in Section 1.

Employer Group Ended Participation subscribers: Only the retiree or their survivor may enroll in coverage. They may enroll a spouse, state-registered domestic partner, or dependents.

Last name

First name

Social Security number

COBRA subscribers: Date PEBB health plan coverage ended:

Employer Group Ended Participation subscribers: Date employer group ended participation:



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Subscriber's last name

Social Security number

1

Subscriber

If you are enrolled in Medicare, this information needs to match your Medicare records to avoid delays in coverage starting.

Social Security number

Date of birth

Sex assigned at birth¹

Last name

Male Female
Gender identity²

First name

Male Female X
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

 You must report your new address to the PEBB 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 13), or calling 1-800-200-1004 (TRS: 711).

Are you or any eligible dependents enrolled in PEBB insurance coverage under another account? Yes No

Dependents cannot be enrolled in two PEBB accounts at the same time. Contact the PEBB Program for help.

If enrolling in COBRA:

- 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 flexible spending arrangement (FSA) or a Limited Purpose 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 the Navia COBRA election notice sent to you, whichever is later.

If your employer group ended participation in PEBB or SEBB coverage: If you were previously enrolled in PEBB retiree term life insurance, you have the option to convert it by calling MetLife at 1-866-548-7139.

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 extent allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit hca.wa.gov/gender-x.

2026 PEBB Continuation Coverage (COBRA/Employer Group Ended Participation) Election/Change

Subscriber's last name

Social Security number



You may choose to continue coverage you were enrolled in on the day your PEBB health plan coverage ended. If you terminate all coverage, you will not be eligible to enroll again in PEBB Continuation Coverage unless you regain eligibility

Continue coverage (Select all that apply.)

Medical Dental Vision

If terminating coverage, include reason:

Add coverage (Select all that apply.)

Medical Dental Vision

Termination date:

Terminate coverage (Select all that apply.)

Medical Dental Vision

If enrolling in COBRA, do you receive Social Security Disability? Yes No

If **Yes**, effective date

If **Yes**, attach a copy of your Social Security Disability Award letter. Write your full name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of COBRA coverage.

Are you enrolled in Medicare Part A or Part B?

Part A (hospital)

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

Part B (medical)

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

Medicare number

If Yes, proof is required. Attach a copy of your Medicare benefit verification letter or a copy of your Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **You will not be enrolled until your proof of Medicare is received.**

You could face premium penalties if you don't enroll in Medicare Part A and Part B when you are eligible. You cannot waive Medicare while on COBRA coverage or while enrolled in retiree coverage.



Premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response 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 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/pebb-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 *PEBB Premium Surcharge Attestation Change Form*.

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

No, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

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.

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 182-12-109. 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 PEBB 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/pebb-continuation.

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

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

If your spouse or SRDP is enrolled in Medicare, this information needs to match their Medicare records to avoid a delay in coverage starting.

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	

⚠ 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.

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

If terminating coverage, include reason:

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

Termination date:

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

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 extent allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit hca.wa.gov/gender-x.

If enrolling in COBRA, does this person receive Social Security Disability?

Yes

No

If **Yes**, effective date:

If **Yes**, attach a copy of their Social Security Disability Award letter. Write your full name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of COBRA coverage.

Is this person enrolled in Medicare Part A or B?

Part A (hospital)

Yes

No

If Yes, enter effective date on Medicare card:

Part B (medical)

Yes

No

If Yes, enter effective date on Medicare card:

Medicare number:

If **Yes**, proof is required. Attach a copy of their Medicare benefit verification letter or a copy of their Medicare card to this form. Write the subscriber's full name and last four digits of their Social Security number on the copy. **Your spouse or SRDP will not be enrolled until their proof of Medicare is received.**



Premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

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 3 for instructions on how to respond.

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

No, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

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 PEBB Program requires a \$50 premium surcharge in addition to your monthly medical premium if you enroll your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to 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 PEBB 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 PEBB or SEBB Program or a TRICARE plan?
 - Answer **Yes** if their employer does not offer PEBB or SEBB coverage or a TRICARE plan.
 - Answer **No** if their employer offers PEBB or SEBB 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 *PEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response below.



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

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

No, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

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

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

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

The *PEBB Spousal Plan Calculator* is available at hca.wa.gov/pebb-continuation under *Surcharges*.

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 PEBB 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 PEBB 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/pebb-continuation.

Dependents cannot be enrolled in two PEBB 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 *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

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

If enrolling a child with a disability age 26 or older, attach a *PEBB 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 (attach copy of court order)

Child with a disability age 26 or older

Social Security number

Date of birth

Sex assigned at birth¹

Male Female

Last name

Gender identity²

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 extent 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

Continue coverage (Select all that apply.)

Medical Dental Vision

If terminating coverage, include reason:

Add coverage (Select all that apply.)

Medical Dental Vision

Termination date:

Terminate coverage (Select all that apply.)

Medical Dental Vision

If enrolling in COBRA, does this person receive Social Security Disability? Yes No

If **Yes**, effective date:

If **Yes**, attach a copy of their Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of COBRA coverage.

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

Part A (hospital)

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

Part B (medical)

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

Medicare number:

If Yes, proof is required. Attach a copy of their Medicare benefit verification letter or a copy of their Medicare card to this form. Write the subscriber's full name and the last four digits of their Social Security number on the copy. **Your dependent will not be enrolled until their proof of Medicare is received.**



Premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 or older in medical coverage. If you check Yes or do not check any boxes below, you will be charged the \$25-per-account tobacco use premium surcharge in addition to your monthly medical premium. See page 3 for instructions on how to respond.

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

No, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

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.

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 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

Add or change medical plan

Add or change dental plan

Add or change vision plan

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

The PEBB 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, the subscriber's dependents, or both. To disenroll from a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), submit the *PEBB Medicare Plan Disenrollment Form* (form D). The change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c). The PEBB 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 legal responsibility for support ahead of adoption, you should notify the PEBB Program by submitting the required forms as soon as possible. Doing so will ensure timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth or adoption, or the date the legal responsibility is assumed ahead of adoption.

In most cases, the enrollment or change will be effective the first day of the month after the date of the event or the date we receive the form, whichever is later. If that day is on the first of the month, the change begins on that day. Exceptions apply for new enrollment in a PEBB Medicare Supplement plan, a Medicare Advantage with Part D plan, or UMP Classic Medicare with Part D (PDP).

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 toward their employer-based group health plan.

Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the 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 PEBB health plan coverage from Medicaid or CHIP.

Subscriber or dependent loses eligibility for Medicare or enrolls in or terminates enrollment in a Medicare Advantage plan or Medicare Part D plan.

Subscriber or dependent gains, loses, or has a change in low-income subsidy (LIS) eligibility.

Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *PEBB Extended Dependent Certification* and *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes, available at hca.wa.gov/pebb-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 *PEBB Declaration of Tax Status* if enrolling a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes.

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 PEBB Program's annual open enrollment.

A dependent moves from another country to live within the United States or moves from within the United States to live in another country and the move 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's or dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).

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 PEBB Program).

Subscriber or dependent enrolls in Medicare or loses eligibility under Medicare or enrolls or terminates enrollment in a Medicare Advantage Prescription Drug plan or a Medicare Part D plan.

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 or the dependent's new residence, the subscriber may select a new dental plan.

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Medical plan selection

Choose one medical plan. You can find information about medical plan options on HCA's website at hca.wa.gov/pebb-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 is at the end of this form.

If you or an enrolled dependent are in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP), and are moving to another type of medical plan, also submit a *PEBB Medicare Plan Disenrollment Form* (form D) with this form. **Note:** If you choose a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), complete Section 9 of this form.

These plans have specific service areas. If you move out of the service area and your current medical plan is no longer available, you must select a new plan. If you do not, the PEBB Program will enroll you in a plan. You must report your new address to the PEBB Program and request a plan change **no later than 60 days** after you move.

If you permanently live outside of the United States, PEBB medical plan enrollment terminates on the last day of the month as required by federal law.

 Plan contact information is at the end of this form.

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

Kaiser Permanente NW Classic
 Kaiser Permanente NW Consumer-Directed Health Plan⁴
 Kaiser Permanente NW Senior Advantage with Part D²

Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)

Kaiser Permanente WA Classic⁵
 Kaiser Permanente WA Consumer-Directed Health Plan⁴
 Kaiser Permanente WA Medicare Advantage with Part D^{2,3}
 Kaiser Permanente WA SoundChoice⁵
 Kaiser Permanente WA Value⁵

Premiera Blue Cross

Medicare Supplement Plan G⁶

Uniform Medical Plan (UMP), administered by Regence BlueShield and ArrayRx

UMP Classic⁴
 UMP Classic Medicare with Part D (PDP)⁷
 UMP Select⁴
 UMP Consumer-Directed Health Plan⁴

UnitedHealthcare Medicare Advantage Prescription Drug

UnitedHealthcare PEBB Balance (MAPD)⁷
 UnitedHealthcare PEBB Complete (MAPD)⁷

1. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

2. This Medicare plan is available only in certain counties. See "Medical plans available by county" at hca.wa.gov/pebb-continuation.

3. If you select this plan for yourself, you must select Kaiser Permanente WA Classic, SoundChoice, or Value plan for any dependents on your account who are not enrolled in Medicare.

4. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.

5. Only non-Medicare members can enroll in this plan. If you select this plan for yourself, any dependents on your account who are enrolled in Medicare will be enrolled in Kaiser Permanente WA Medicare Advantage with Part D.

6. Also submit Form B to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.

7. These plans are only available to Medicare members who permanently live in the United States. Enrollment in these plans may not be retroactive. If the required forms are received after the date PEBB health plan coverage is to begin, you and your enrolled dependents will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare or UMP Classic Medicare with Part D (PDP) coverage begins. Any non-Medicare members on your account will continue to be enrolled in UMP Classic.

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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 #03000), 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 #03100), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network.

Willamette Dental of Washington (Group WA82), administered by Willamette Dental of Washington, Inc. You must select and receive care from a primary care dental provider in the Willamette Dental network.

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Vision plan selection

Choose one vision plan (available to non-Medicare members only). Before you enroll, make sure the provider you want to use accepts the specific plan you choose. A vision plan must be selected for all non-Medicare members (subscribers or dependents) who want vision benefits; all non-Medicare members will be enrolled in the same vision plan. For Medicare members, vision is included in your medical plan, excluding Premera Plan G.

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")

8

Signature

I have received and read the PEBB Continuation Coverage Election Notice, including appendices (only for subscribers enrolling in COBRA coverage). 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 plans. 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 insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB health plan coverage. The PEBB Program will verify eligibility for my dependents and me. 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 coverage premium surcharge in addition to my

monthly medical premium.

I understand if I enroll in PEBB 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.

I understand I am responsible for paying any Medicare Part D late enrollment penalty associated with the Medicare Advantage with Part D plan or Uniform Medical Plan Classic Medicare Part D (PDP) to the plan.

If the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) determines that you owe a Medicare Part D late enrollment penalty, you will be billed separately by the plan. You are required to pay the Part D late enrollment penalty separately to the plan.

If I enroll in a consumer-directed health plan 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 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.

If I am electing to enroll in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP),

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Subscriber's last name

Social Security number

I certify that I have read and understand the Statement of Understanding in Section 9. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage contract. I understand that enrollment in an MAPD or UMP Classic Medicare with Part D (PDP) plan may not be retroactive. If I elect to enroll in a Kaiser MAPD plan, and the required forms are received by the PEBB Program after the date PEBB insurance coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser plan during the gap month(s) prior to when Kaiser MA coverage begins. If I elect to enroll in a UnitedHealthcare MAPD or UMP Classic Medicare with Part D (PDP) plan, and the required forms are received by the PEBB Program after the date PEBB insurance coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic during the gap month(s) prior to when

the UnitedHealthcare MAPD or UMP Classic Medicare with Part D (PDP) plan begins. **This form cannot be signed more than 90 days before the effective date of this coverage.** (See Statement of Understanding in Section 9 for coverage effective date.)

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/Employer Group Ended Participation) Election/Change* forms previously submitted to the PEBB Program

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

Subscriber's signature

Date

Spouse or SRDP signature [only required if enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP)]

Date

Dependent signature [only required if enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP)]

Date

Form return

Submit form and documentation using one of the methods below.

Mail to:

Washington State 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:

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/pebb-continuation.

Medicare Advantage with Part D and UMP Classic Medicare with Part D (PDP) agreement

We offer four Medicare Advantage with Part D plans: Kaiser Permanente of the Northwest Senior Advantage with Part D, Kaiser Permanente of Washington Medicare Advantage with Part D, UnitedHealthcare PEBB Balance, and UnitedHealthcare PEBB Complete. We also offer UMP Classic Medicare with Part D (PDP). **If you or your dependent are NOT enrolling in one of these plans, skip this section.**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected in Section 5 of this form, as long as this form is signed prior to the effective date, all medical or prescription drug services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) when required will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) plan at a time. By enrolling in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), I authorize CMS to provide information to the plan I selected confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including — but not limited to — physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision or coordination of benefits or to professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to Original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) by sending a written request to the PEBB Program with Form D. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) providers.

I understand that as a member of the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected is effective the day PEBB insurance begins, or the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later. If I submit this form during the PEBB Program's annual open enrollment, then my enrollment is effective January 1 of the following year.

Some members are required to pay a Part D late enrollment penalty. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty is determined by CMS and depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

I understand that upon confirmation from CMS, the plan will send me written notice of my effective date of enrollment. I understand that when my coverage begins, I must get all of my medical (and prescription drug, if applicable) benefits from the plan. Note: Until you have received written notification of your effective date, you should not drop any supplemental insurance

2026 PEBB Continuation Coverage (COBRA/Employer Group Ended Participation) Election/Change

Subscriber's last name

Social Security number

you have in effect now.

This form represents your temporary Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) identification card. Until you receive your plan identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage with Part D organization or UMP Classic Medicare with Part D (PDP) provides the member, prior to the effective date, evidence of health insurance coverage so they may begin using the plan services as of the effective date of enrollment.

Please contact the plans if you need information in another language or format.

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and UnitedHealthcare which are Medicare Advantage with Part D plans; UMP Classic Medicare with Part D (PDP) are Employer Group Waiver Plans, all of which have contracts with the federal government. Enrollment depends on contract renewal.

Medicare enrollment supplemental demographic information

Providing this demographic information is **optional** and will not affect your enrollment.

Preferred language other than English

Spanish

Other (please indicate)

No selected preference

Preferred accessible format

Braille

Large print

Audio CD

Data CD

No selected preference

Subscriber

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

Not of Hispanic, Latino/a, or Spanish origin

Puerto Rican

Another Hispanic, Latino/a, or Spanish origin

Mexican, Mexican American, Chicano/a

Cuban

I choose not to answer

Spouse or SRDP

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

Not of Hispanic, Latino/a, or Spanish origin

Puerto Rican

Another Hispanic, Latino/a, or Spanish origin

Mexican, Mexican American, Chicano/a

Cuban

I choose not to answer

Dependent

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

Not of Hispanic, Latino/a, or Spanish origin

Puerto Rican

Another Hispanic, Latino/a, or Spanish origin

Mexican, Mexican American, Chicano/a

Cuban

I choose not to answer

Which of the following best describes you? Select all that apply.

White

Black or African American

American Indian or Alaska Native

Asian Indian

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Asian

Native Hawaiian

Samoan

Guamanian or Chamorro

Other Pacific Islander

A race/ethnicity not listed

I choose not to answer

Which of the following best describes you? Select all that apply.

White

Black or African American

American Indian or Alaska Native

Asian Indian

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Asian

Native Hawaiian

Samoan

Guamanian or Chamorro

Other Pacific Islander

A race/ethnicity not listed

I choose not to answer

Which of the following best describes you? Select all that apply.

White

Black or African American

American Indian or Alaska Native

Asian Indian

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Asian

Native Hawaiian

Samoan

Guamanian or Chamorro

Other Pacific Islander

A race/ethnicity not listed

I choose not to answer

PEBB 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)
Medicare members: 1-877-221-8221 (TRS: 711)

Kaiser Foundation Health Plan of Washington

2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636, TTY: 1-800-833-6388
Medicare members: 1-888-901-4600

Premiera Blue Cross

PO Box 327, MS 295
Seattle, WA 98111
425-918-4000

Uniform Medical Plan, administered by Regence BlueShield (for medical benefits)

PO Box 1106
Lewiston, ID 83501-1106
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by ArrayRx

(for prescription drug benefits)
Non-Medicare members:
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

Medicare members:
PO Box 40327
Portland, OR 97240-0327
1-833-599-8539 (TRS: 711)

UnitedHealthcare

185 Asylum Ave.
Hartford, CT 06103
1-855-873-3268

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

Vision Care Processing Unit
200 Park Ave.
New York, NY 10166
1-888-496-4275
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
1-866-548-7139
TTY: 1-800-428-4833

Vision Service Plan (UMP Classic Medicare vision plan)

PO Box 997100
Sacramento, CA 95899-7100
1-844-299-3041 (TTY: 1-800-428-4833)