Clear form

2021 **PEBB Continuation Coverage (COBRA) Election/Change**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

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.

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 in coverage until we receive your first payment. If HCA does not receive your first payment during this 45-day timeframe, you will not be enrolled, and you will lose your rights for PEBB Continuation Coverage (COBRA). Premiums and applicable premium surcharges are due from the date your other coverage ended.

All forms and documents 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) Election/Change* forms previously submitted.

Remember to read and sign Section 6. To enroll or remove dependents, complete Section 7 at the end of this form.

Employee or retiree information only

Last name

First name

Social Security number

Date PEBB health plan coverage ended

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

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**.

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security 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

If you move, 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 to the address listed on page 11, calling 1-800-200-1004 (TRS: 711), or calling 1-800-200-1004 (TRS: 711).

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

Yes No

Continue coverage (Select all that apply.)

Medical Dental

Add coverage (Select all that apply.)

Medical Dental

Terminate coverage (Select all that apply.)

Medical Dental

Termination date

If terminating coverage, include reason

You may elect to continue coverage you were enrolled in on the day your PEBB health plan coverage ended. 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.

If you terminate all coverage, you will not be eligible to enroll again in PEBB Continuation Coverage unless you regain eligibility.

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Are you covered by another group medical plan?

Yes No If yes, effective date

Are you covered by another group dental plan?

Yes No If yes, effective date

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 Medicare Part A or Part B?

Part A (hospital)

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

Part B (medical)

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

If **Yes**, proof is required. Attach a copy of all pages of your entitlement letter or a copy of your Medicare card to this form. Write your last name and the last four digits of your Social Security number on the copy so we can identify your acocunt. You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

Premium surcharges only apply to subscribers who are not 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 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 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**.

If you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge. 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*.

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

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. If this is a change to a previous attestation, use the *PEBB Premium Surcharge Attestation Change Form*.

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 noted in the *PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or state-registered domestic partner (SRDP), as defined by Washington Administrative Code 182-12-109, you wish to cover or remove from coverage. To enroll children, please complete Section 7 at the end of this form. Your spouse or SRDP cannot be enrolled in two PEBB medical or dental accounts at the same time.

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

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

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

Terminate coverage (Select all that apply.)
☐ Medical ☐ Dental Termination date

If terminating coverage, include reason

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

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**.

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Subscriber's last name

Social Security number

Is this person covered by another group medical plan?

☐ Yes ☐ No If yes, effective date

Is this person covered by another group dental plan?

☐ Yes ☐ No If yes, effective date

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 SRDP'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.

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

Part A (hospital)

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

Part B (medical)

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

If **Yes**, proof is required. Attach a copy of all pages of their entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account.

Premium surcharges only apply to subscribers who are not 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 the *2021 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/pebb-continuation** for instructions on how to respond.

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

☐ 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. 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 or accessed one of the tobacco cessation resources noted in the *2021 PEBB Premium Surcharge Attestation Help Sheet*.

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

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 monthly $50 premium surcharge in addition to your monthly medical premium if you are enrolling 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. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond.

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

☐ I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

If you check **Yes** or do not check any boxes below, you will be charged the $50 spouse or SRDP coverage premium surcharge.

☐ **Yes**, I am subject to the $50 premium surcharge.
I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *PEBB Spousal Plan Calculator* online.

☐ **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* online. 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 to 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*.

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

3 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, continue to Section 4.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for you or your enrolled dependents

☐ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child), the PEBB Program must receive this form and proof of the event **no later than 60 days** after the last day of the month the dependent loses eligibility. Coverage will be terminated the last day of the month of loss of eligibility. If applicable, provide your former dependent's new address:

Street address

Address line 2

City State

ZIP/Postal code County

Additional 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

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

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 dependent, or both. To disenroll from a Medicare Advantage plan or Medicare Advantage Prescription Drug (MAPD) plan, the change in enrollment must be allowable under 42 C.F.R Sec. 422.62(b) and 42 C.F.R. Sec. 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, has adopted or has 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, we must receive the required forms **no later than 60 days** after the date of the birth, 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. Exceptions apply for new enrollment in a PEBB Medicare Supplement plan, Medicare Advantage plan, or an MAPD plan.

Date of change:

Check the box next to the corresponding events below.

The following events allow a subscriber to enroll dependents or change medical or dental 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 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.
- 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 under IRC Section 152, as modified by IRC Section 105(b).
- Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal responsibility for support ahead of adoption. You must also submit a *2021 PEBB Declaration of Tax Status* if enrolling a SRDP or their child to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section105(b).

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

The following events allow a subscriber to enroll 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.

The following events allow a subscriber to change medical or dental plans

- Subscriber or dependent has a change in residence that affects health plan availability.
- Subscriber or dependent enrolls in or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug plan or Medicare Part D plan.
- Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- 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's last name

Social Security number

4 Medical plan selection

Contact the plans with questions about benefits and providers. Their contact information is on page 11.
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 this form, sending a written request to the address listed on page 12, or calling 1-800-200-1004 (TRS: 711).

Kaiser Foundation Health Plan of the Northwest[1]

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2,5]
- ☐ Kaiser Permanente NW Senior Advantage[3]

Kaiser Foundation Health Plan of Washington[1]

- ☐ Kaiser Permanente WA Classic[7]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA Medicare Plan[3,4]
- ☐ Kaiser Permanente WA SoundChoice[6,7]
- ☐ Kaiser Permanente WA Value[7]

Premera Blue Cross

- ☐ Premera Blue Cross Medicare Supplement Plan G[8]

Uniform Medical Plan (UMP), administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Select[5]
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus—Puget Sound High Value Network[1,5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[1,5]

UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)[9]

- ☐ UnitedHealthcare PEBB Balance
- ☐ UnitedHealthcare PEBB Complete

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. KFHPNW Medicare plans have a larger service area.
3. These Medicare plans are available only in certain counties. See "Medical plans available by county" on HCA's website at **hca.wa.gov/pebb-continuation**. Also submit Form C with this form if you live in a county where a Medicare Advantage plan is available.
4. If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.
5. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.
6. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.
7. Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.
8. 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.
9. Also submit Form C to enroll in these plans. They are only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.

2021 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name | Social Security number

5 Dental plan selection

Choose one dental plan. 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 only 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)

Premera Blue Cross
PO Box 327
Seattle, WA 98111-0327
1-800-817-3049 (TTY: 1-800-842-5357)

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)

UnitedHealthcare
Customer Service Department
PO Box 30770
Salt Lake City, Utah 84130-0770
1-855-873-3268

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)

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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.

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.

If I am enrolling 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.

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) 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 or remove 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 or remove from coverage. Enrolled children 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. 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 they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, attach a *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 13 and 14 and attach to 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

Continue coverage (Select all that apply.)

Medical Dental

Add coverage (Select all that apply.)

Medical Dental

Terminate coverage (Select all that apply.)

Medical Dental

Termination date

If terminating coverage, include reason

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**.

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Subscriber's last name

Social Security number

Is this person covered by another group medical plan?

Yes No If yes, effective date:

Is this person covered by another group dental plan?

Yes No If yes, effective date:

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.

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

Part A (hospital)

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

Part B (medical)

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

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account. You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

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

Tobacco use premium surcharge

Response 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 tobacco use premium surcharge in addition to your monthly medical premium.

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

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. If this is a change to a previous attestation, please submit the *PEBB Premium Surcharge Attestation Change Form*.

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*.

If adding more dependents, copy pages 13 – 14 and attach to this form.