Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

2017 COBRA Election/Change (Continuation of Coverage)

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** after the date your employer-sponsored coverage ends or from the postmark on the *PEBB Program Continuation Coverage Election Notice* packet sent to you, whichever is later.
- **We must receive your first payment before we can enroll you.** Premiums and applicable surcharges are due back to the date your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all *COBRA Election/Change* forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form(s).

All forms and documents are available at **www.hca.wa.gov/public-employee-benefits** or by calling 1-800-200-1004.

Employee or retiree information only	Employee or retiree name	
	Employee or retiree Social Security number	Date employer coverage ended (mm/dd/yyyy)

Section 1: Subscriber Information

Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number ( )	Home phone number ( )

☐ **Continue coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only

You may elect to continue coverage you were enrolled in on the day your employer-sponsored coverage ended. If you have optional life insurance and wish to continue it, complete and submit the *Group Life Portability Application* (available from your former employer). MetLife must receive the form **no later than 31 days** after your employer-sponsored coverage ends.
If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions **no later than 60 days** after the date they provide you with the notice of your continuation right.

☐ **Cancel coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only

Reason_____ Cancel date_____

I understand that I am forfeiting all further rights to enroll in PEBB Program benefits cancelled above unless I regain eligibility.

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_____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ☐ Yes ☐ No If yes, effective date_____

Part B (medical) ☐ Yes ☐ No If yes, effective date_____

If yes, proof is required. Attach a copy of your Medicare card to this form.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 1: Subscriber Information *(continued)*

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B, and you or a family member (age 13 or older) enrolled on your PEBB Program medical coverage 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. See the 2017 Premium Surcharge Help Sheet *at* **www.hca.wa.gov/public-employee-benefits** *for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.*

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.
- ❑ NO, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have used the tobacco cessation resources noted in the *2017 Premium Surcharge Help Sheet*.

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB Program medical or dental accounts at the same time. ***If adding a state-registered domestic partner, you must provide proof of eligibility within PEBB Program's enrollment timelines, or the state-registered domestic partner will not be enrolled.*** *A list of documents we will accept to verify eligibility is available at* **www.hca.wa.gov/public-employee-benefits**

Relationship to subscriber

❑ Spouse: date of marriage_____ ❑ State-registered domestic partner: date registered _____

Social Security number	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	
❑ **Add coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	
❑ **Cancel coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	

Reason _____ Cancel date _____

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

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of the spouse's or state-registered domestic partner's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

If yes, proof is required. Include a copy of the spouse's or state-registered domestic partner's Medicare card with this form.

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Check one:

- ❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ❑ YES, I am subject to the $25 premium surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months.
- ❑ NO, I am not subject to the $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the *2017 Premium Surcharge Help Sheet*.

(this section continued on next page)

Subscriber's last name	First name	Middle initial	Social Security number

Section 2: Spouse or State-Registered Domestic Partner Information *(continued)*

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has elected not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2017 Premium Surcharge Help Sheet *and the* 2017 Spousal Plan Calculator *at* **www.hca.wa.gov/public-employee-benefits**. *To change your attestation, use the* 2017 Premium Surcharge Change Form. *If you check YES below or leave this section blank, you will pay the monthly surcharge.*

Does the spouse or state-registered domestic partner coverage surcharge apply to you? Check one:

- ❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ❑ YES, I am subject to the $50 premium surcharge. I used the *2017 Premium Surcharge Help Sheet* and completed the *2017 Spousal Plan Calculator* online.
- ❑ NO, I am not subject to the $50 premium surcharge. I used the *2017 Premium Surcharge Help Sheet* and, if needed, completed the *2017 Spousal Plan Calculator* online.

Which questions, if any, on the *2017 Premium Surcharge 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

- ❑ PEBB Program to determine. I am completing and submitting the printed *2017 Spousal Plan Calculator* from **www.hca.wa.gov/public-employee-benefits**.

Section 3: Family Member Information (such as child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB Program medical or dental accounts at the same time. Attach a completed Extended Dependent Certification *form if enrolling an extended dependent. If enrolling a dependent with a disability age 26 or older, submit a completed* Certification of Dependent With a Disability *form and return as instructed on the form.*

A	**Relationship to subscriber**	*Check only if age 26 or older.* Disabled? ❑ Yes ❑ No	Sex ❑ M ❑ F	Social Security number

Extended dependent validated by court order? ❑ Yes ❑ No

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

- ❑ **Continue coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only
- ❑ **Add coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only
- ❑ **Cancel coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only

Reason _____ Cancel date _____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of the family member's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

If yes, proof is required. Attach a copy of the family member's Medicare card to this form.

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? *(Response required for family members ages 13 or older.)* Check one:

- ❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ❑ YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.
- ❑ NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the *2017 Premium Surcharge Help Sheet*.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 3: Family Member Information *(continued)*

B	Relationship to subscriber	*Check only if age 26 or older.* Disabled? ❑ Yes ❑ No	Sex ❑ M ❑ F	Social Security number

Extended dependent validated by court order? ❑ Yes ❑ No

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber)	Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only
❑ **Add coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only
❑ **Cancel coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only

Reason _____ Cancel date _____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of the family member's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

If yes, proof is required. Attach a copy of the family member's Medicare card to this form if we don't already have a copy.

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? *(Response required for family members ages 13 or older.)*
Check one:
❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
❑ YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.
❑ NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the *2017 Premium Surcharge Help Sheet*.

Section 4: Changes to an Existing Account

Are you making changes to an existing account?

❑ **Yes** **If yes, what changes?** *(Check all that apply in the sections below.)*
❑ **No** *If no, go to Section 5.*

Changes you can make anytime

Give date of event/change _____

❑ Name change ❑ Address change ❑ Cancel medical coverage ❑ Cancel dental coverage

❑ Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of state-registered domestic partnership, death, or other loss of eligibility under PEBB Program rules), **we must receive this form no later than 60 days after the last day of the month the dependent loses eligibility for health plan coverage**. Coverage will be cancelled the last day of the month of loss of eligibility. If applicable, provide former dependent's new address:

_____

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested.

❑ Add dependent(s) ❑ Change medical plan ❑ Change dental plan

(this section continued on next page)

Subscriber's last name	First name	Middle initial	Social Security number

Section 4: Changes to an Existing Account *(continued)*

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. **The PEBB Program must receive this form and proof of the event no later than 60 days after the event.** However, if adding a newborn or adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.

Check the box next to each change you are requesting and indicate the corresponding event(s). See the numbers beside each change to verify that your requested change may be allowed. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

- ❑ **Add dependent(s)** (allowable under events 1, 2, 3, 4, 5, 6, 7, 8, 10, 11,12)
- ❑ **Change medical plan** (allowable under events 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15)
- ❑ **Change dental plan** (allowable under events 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15)

Give date of event_____

Check the box(es) next to the corresponding event(s). The event number below must be listed next to the change(s) you are requesting above.

- ❑ 1. Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ❑ 2. Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form available at **www.hca.wa.gov/public-employee-benefits**.
- ❑ 3. Child becomes eligible as a dependent with a disability. Also complete a *Certification of Dependent With a Disability* form available at **www.hca.wa.gov/public-employee-benefits**.
- ❑ 4. 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.
- ❑ 5. Subscriber has a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward his or her employer-based group health plan.
- ❑ 6. Subscriber's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.
- ❑ 7. 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.
- ❑ 8. Subscriber's dependent moves from outside the United States to live within the United States or moves from inside the United States to live outside the United States.
- ❑ 9. Subscriber or dependent has a change in residence that affects health plan availability.
- ❑ 10. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.
- ❑ 11. Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ 12. Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB Program health plan coverage from Medicaid or CHIP.
- ❑ 13. Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ❑ 14. Subscriber or dependent's current health plan becomes unavailable because the subscriber or dependent is no longer eligible for a health savings account.
- ❑ 15. Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

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

2017 COBRA Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 5: Medical Plan Selection *Check appropriate box(es).*

Contact the plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative
- ☐ Group Health Classic
- ☐ Group Health Medicare Plan[1,2]
- ☐ Group Health SoundChoice[6]
- ☐ Group Health Value

Group Health Options Inc.
- ☐ Group Health Consumer-Directed Health Plan[3]

Kaiser Foundation Health Plan of the Northwest
- ☐ Kaiser Permanente Classic
- ☐ Kaiser Permanente Consumer-Directed Health Plan[3]
- ☐ Kaiser Permanente Senior Advantage[1]

☐ **Medicare Supplement Plan F, administered by Premera Blue Cross[4]**

Uniform Medical Plan, administered by Regence BlueShield
- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan[3]
- ☐ UMP Plus–Puget Sound High Value Network[5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[5]

[1] **These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available. (See www.hca.wa.gov/public-employee-benefits for medical plans available by county.)**

[2] **If you cover dependents not enrolled in Medicare Part A and Part B, also select Group Health Classic, SoundChoice, or Value for these dependents.**

[3] **These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB Program coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.**

[4] **Also complete and return the *Group Medicare Supplement Enrollment Application* (form B) to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.**

[5] **This plan is not available to Medicare Part A and Part B subscribers and their dependents.**

[6] **This plan is available only if at least one covered family member is not enrolled in Medicare Part A and Part B. Family members enrolled in Medicare Part A and Part B will be enrolled in Group Health's Medicare Plan.**

Section 6: Dental Plan Selection *Check only one.*

Before you select a dental plan, be sure your provider(s) participate with that plan.

Preferred Provider Organization
You can choose any dental provider and change providers at anytime.

☐ Uniform Dental Plan, administered by Delta Dental of Washington **(Group #3000)**

Managed-Care Plans
You must choose a provider from the dental plan network. Before you select a managed-care plan, be sure to call the dental plan to verify your provider is in their network and fill in the requested information below.

☐ DeltaCare, administered by Delta Dental of Washington **(Group #3100)**
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)**
Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

(continued)

2017 COBRA Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 7: Signature *Required*

I have received and read the *PEBB Program Continuation Coverage Election Notice,* including any appendices. By signing 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 family members and I may also lose PEBB Program 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 providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of PEBB Program insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB Program insurance coverage. The PEBB Program will verify eligibility for me and my family members. 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 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.

This form replaces all *COBRA Election/Change* forms previously submitted to the PEBB Program.

HCA's Privacy Notice:
We will keep your information private as allowed by law. To see our Privacy Notice, go to **www.hca.wa.gov**.

Subscriber's signature_____ **Date** _____

Please sign and date this form.

Mail to:	**If payment is enclosed, make it payable to Health Care Authority and mail to:**	**Or hand-deliver to:**
Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684	Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695	Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

2017 PEBB Program Medical Contractors

Group Health Cooperative
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc.
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 711

Premera Blue Cross
P.O. Box 327
Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Ave., Suite 235, Seattle, WA 98101
1-888-849-3681 or TTY 711

2017 PEBB Program Dental Contractors

DeltaCare, administered by Delta Dental of Washington
9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan
administered by Delta Dental of Washington
9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-537-3406

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