Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

# Temporary changes to PEBB Continuation Coverage deadlines

Some deadlines in this document have changed because of the Health Care Authority's response to the COVID-19 state of emergency. The Governor announced the state of emergency on February 29, 2020.

On April 2, 2020, the PEB Board passed resolutions to:

- **Extend the enrollment deadline for PEBB Continuation Coverage to 30 days past the date the Governor ends the state of emergency.**
    - This means you may have extra time to enroll in PEBB Continuation Coverage. For example, if your last day to enroll is April 30, and the state of emergency ends May 15, then your enrollment period will be extended to June 15.
    - If your last day to enroll occurs more than 30 days after the last day of the state of emergency, your deadline **will not** be extended. For example, if your last day to enroll is July 31, and the state of emergency ends May 15, the extended enrollment date will be June 15. Your enrollment deadline will not be extended.
    - The last day of the state of emergency is unknown at this time. We will provide more information to you as it becomes available at **hca.wa.gov/coronavirus.**
- **Extend the maximum continuation coverage period to the last day of the second month after the date the Governor ends the state of emergency.**
    - This means that you may have PEBB Continuation Coverage longer than is described in this document.
    - If your continuation coverage period would have **ended between February 29 and the date that the state of emergency ends,** your coverage will continue to the last day of the second month after the date the state of emergency ends. For example, if your coverage period would have ended April 30, and the state of emergency ends on May 15, your coverage will be extended to July 31.
    - If your continuation coverage period would have **ended after the date the state of emergency ends, but before the two-month extension,** your coverage will only continue until the last day of the second month after the date the state of emergency ends. For example, if the state of emergency ends May 15, and your continuation coverage ends June 30, your coverage will be extended to July 31.
    - If your continuation coverage period ends **on the last day of the two-month extension (or later)**, your coverage **will not** be extended. For example, if your coverage is set to end on October 31, and the state of emergency ends on May 15, your coverage will not be extended. It is already set to end more than two months after the end of the state of emergency.

Your first payment is due 45 days after the last day of your enrollment period, whether or not your enrollment period is extended. Learn more about these emergency resolutions at **hca.wa.gov/coronavirus**.

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

# 2020 PEBB Continuation Coverage (COBRA) Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay 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.
- 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 as described above. Premiums and applicable premium surcharges are due back to the date your other coverage ended. If we do not receive your payment within this 45-day timeframe, you will not be enrolled, and you will lose your right to PEBB Continuation Coverage.
- List eligible dependents you wish to cover or remove from coverage. This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms submitted in the past.
- If adding a dependent child with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form.
- All forms and documents are available at **hca.wa.gov/erb** under *Forms & publications* or by calling 1-800-200-1004 (TRS: 711) and selecting option 5.

| **Employee or retiree information only** | Employee or retiree name | |
|---|---|---|
| | Employee or retiree Social Security number | Date PEBB health plan 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) | Home phone number ( ) | Alternative phone number ( ) |
|---|---|---|---|
| | | | |

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

You may 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, contact Navia Benefit Solutions at 1-800-669-3539. You must elect to continue your Medical FSA **no later than 60 days** from the date on Navia's election notice, which was mailed to you.

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

Include reason _____ Terminate date _____

If I terminate all my coverage, I understand that I am forfeiting all further rights to enroll in PEBB benefits 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 Medicare Part(s) A and/or B?**

**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. Write your full name and the last four digits of your Social Security number on the copy. **Note:** 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.



*(continued)*

## 2020 PEBB Continuation Coverage (COBRA) Election/Change

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

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

**Tobacco use premium surcharge**

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your PEBB medical plan uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check **Yes** or leave this section blank, you will be charged the monthly $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/erb** for instructions on how to respond.

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

☐ **YES, I am subject to the $25 premium surcharge.** I have used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 premium surcharge.** I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation 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 182-12-109, you wish to cover or remove from coverage.
- Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a state-registered domestic partner, 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 the dependent's eligibility is available at **hca.wa.gov/erb**.

| **Relationship to subscriber** | ☐ Spouse: Date of marriage_____<br>☐ State-registered domestic partner: date registered _____ Also attach a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b). | Date of birth (mm/dd/yyyy) |
|---|---|---|

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

| 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

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

If terminating coverage, include reason _____ Termination 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 your 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. Attach a copy of your spouse or state-registered domestic partner's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** 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—if enrolling in medical coverage**

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

☐ **YES, I am subject to the $25 premium surcharge.** This person has used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 premium surcharge.** This person has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

*(continued)*

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

## Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. If you check **Yes** below or leave this section blank, you will be charged the monthly $50 premium surcharge.

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

__ **Yes, I am subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 Spousal Plan Calculator* online.

__ **No, I am not subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and if needed, completed the *2020 Spousal Plan Calculator* online.

**If NO, which questions on the *2020 PEBB Premium Surcharge Attestation Help Sheet* did you check NO (if any)?** Check all that apply. Question 1 is not applicable.

__ Question 2 __ Question 3 __ Question 4 __ Question 5 __ Question 6

__ **PEBB Program to help determine if the premium surcharge applies.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *2020 PEBB Spousal Plan Calculator.*

## Section 3: Dependent information

List eligible dependents including children as defined in WAC 182-12-260(3). Use additional forms for more dependents.

- List eligible dependents you wish to cover or remove from coverage.
- Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *2020 PEBB Declaration of Tax Status* form 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, also attach a *2020 PEBB Extended Dependent Certification* form.
- If enrolling a dependent child with a disability age 26 or older, also attach a *2020 PEBB Certification of a Dependent Child With a Disability* form and return as instructed on the form.

| **A** | Last name | First name | Middle initial | Sex __M __F | Social Security number |
|---|---|---|---|---|---|
| | | | | | |

| Relationship to subscriber | | Date of birth (mm/dd/yyyy) |
|---|---|---|
| | __ Child<br>__ Stepchild *(not legally adopted)*<br>__ Extended dependent *(attach copy of court order)* | __ Child with a disability *(check only if age 26 or older)* |

| 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

__ **Terminate coverage:** *(select one)* __ Medical and dental __ Medical only __ Dental only

If terminating coverage, include reason _____ Termination 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 your dependent's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

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

**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 dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** 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.

**Tobacco use premium surcharge – if enrolling in medical coverage**

**Does the tobacco use premium surcharge apply to this dependent?** Check one:

__ **YES, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months.

__ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*



*(continued)*

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

## Section 3: Dependent Information *(continued)*

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

Relationship to subscriber: ☐ Child ☐ Stepchild *(not legally adopted)* ☐ Extended dependent *(attach copy of court order)* ☐ Child with a disability *(check only if age 26 or older)*

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

If terminating coverage, include reason _____ Termination 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 your dependent's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

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

**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 dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** 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.

**Tobacco use premium surcharge – if enrolling in medical coverage**

**Does the tobacco use premium surcharge apply to this dependent?** Check one:

☐ **YES, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation 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 ☐ Terminate medical coverage ☐ Terminate dental coverage

☐ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB benefits). **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.** If applicable, provide former dependent's new address: _____

### Additional changes you can make during annual open enrollment (November 1–30)

All changes become effective January 1 of the following year. Check the box(es) next to the change requested.

☐ Add dependent(s) or remove dependents ☐ Change medical plan ☐ Change dental plan

*(continued)*

| 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.

**We must receive this form and proof of the event no later than 60 days after the event occurs.** 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. Give date of event _____ Check the box next to the corresponding event(s) below.

**Add dependent(s), change medical plan, and/or change dental plan:**

- ☐ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2020 PEBB Extended Dependent Certification* form available at **hca.wa.gov/erb**.
- ☐ 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.
- ☐ 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 becomes entitled to or loses eligibility for 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.

**Add dependent(s):**

- ☐ 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.
- ☐ Subscriber's dependent moves from another country to live within the United States or moving from inside the United States to live in another country and that change in residence resulted in the dependent losing their health insurance.

**Change medical plan and/or change dental plan:**

- ☐ Subscriber or dependent has a change in residence that affects health plan availability.
- ☐ Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a 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).

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

*(continued)*

## 2020 PEBB Continuation Coverage (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 details about benefits; their contact information is at the end of this form.**

**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 Medicare Supplement Plan G**[8]

**Uniform Medical Plan, administered by Regence BlueShield**
- ☐ UMP Classic
- UMP Consumer-Directed Health Plan[5]

**UMP Plus** (select a network)
- ☐ UMP Plus–Puget Sound High Value Network[1,5]
- ☐ UMP Plus–UW Medicine Accountable Care Network [1,5]

[1] These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program **no later than 60 days** after you move.

[2] Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

[3] These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the *2020 PEBB Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available. (See **hca.wa.gov/erb** for medical plans available by county.)

[4] If you cover dependents not enrolled in Medicare Part A and Part B, you must also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.

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

[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] This plan is available only if at least one covered member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA's Medicare Plan.

[8] Also submit the *Group Medicare Supplement Enrollment Application* (form B) to enroll in Medicare Supplement Plan G.

## Section 6: Dental plan selection *Check only one.*

Before you select a dental plan, call the plan to make sure your provider accepts the specific plan and plan group. The plans' contact information is located at the end of this form.

**Preferred Provider Organization (PPO)**

☐ **Uniform Dental Plan** (Group #3000), 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 #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider 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) You will select and receive care from a primary care dental provider 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.

*(continued)*

## 2020 PEBB Continuation Coverage (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 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 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.

This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms submitted to the PEBB Program in the past.

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

**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<br>PO Box 42684<br>Olympia, WA 98504-2684 | Washington State Health Care Authority<br>PO Box 42691<br>Olympia, WA 98504-2691 | Washington State Health Care Authority<br>626 8th Ave. SE<br>Olympia, WA 98501 |

**Note: Do not send forms to the addresses below. They are only for your reference.**

### 2020 PEBB Program medical contractors

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

**Kaiser Foundation Health Plan of Washington**
601 Union Street, Suite 3100, Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388

**Uniform Medical Plan, administered by Regence BlueShield**
1800 Ninth Ave., Seattle, WA 98101
1-888-849-3681 or TRS: 711

### 2020 PEBB Program dental contractors

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

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

**Willamette Dental of Washington, Inc.**
6950 NE Campus Way, Hillsboro, OR 97124
1-855-433-6825

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call 1-800-200-1004 (TRS: 711).