E

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2019 Retiree Coverage Change Form

Complete this form to make changes to an existing retiree account. If you are newly eligible and applying to enroll or defer enrollment in retiree insurance coverage, **please use the *Retiree Coverage Election Form* (Form A).**

Section 1: Subscriber information *See attached instruction sheet for more 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 than above)	Apt./unit number	City	State	ZIP Code
County of residence	Date of birth (mm/dd/yyyy)	Home phone number ( )	Alternate phone number ( )	

Section 2: Change to existing retiree account *See attached instruction sheet for more information.*

A. Terminate: I am enrolled in a PEBB retiree health plan, and I want to terminate the following:

❑ Terminate medical* Termination date _________

I understand I am forfeiting all further rights to enroll again unless I regain eligibility. Coverage is automatically terminated for any enrolled dependents.
***Note:** If you terminate medical coverage while also enrolled in dental coverage, your dental will also be terminated. You cannot be enrolled in dental only.

❑ Terminate dental coverage for myself and any dependents

Termination date _________

I understand that I may only terminate this coverage if I have maintained enrollment in a PEBB retiree dental plan for **at least two years**, or if I am deferring (postponing) or terminating from my PEBB retiree health plan as allowed under PEBB rules (see section 7). Coverage is automatically terminated for any enrolled dependents.

Note: To terminate retiree term life insurance, contact MetLife at 1-866-548-7139.

B. Defer: ❑ Defer my coverage*
Except as stated below, this defers coverage for all dependents. Deferral date ___________

If deferring, check the box below that applies to you. Note: You will need to provide proof of continuous coverage in one or more qualifying coverages from the date of deferral (begin and end dates) whenever you return to a PEBB retiree health plan.

❑ Enrolled in a PEBB Program, Washington State school district, charter school, or educational service district-sponsored health plan as a dependent.

❑ Enrolled in employer-based group medical as an employee or employee's dependent, including COBRA coverage or continuation coverage. This does not include an employer's retiree coverage.

❑ Enrolled in medical coverage as a retiree or dependent in a TRICARE plan, CHAMPVA, or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in a PEBB retiree health plan.

❑ Enrolled in a Medicaid program that provides creditable coverage **and** in Medicare Part A and Part B. You may continue to cover eligible dependents who are not eligible for creditable coverage under Medicaid.

❑ **Non-Medicare retirees only:** enrolled in a qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

**Deferral is prospective from the date Form E is received or a future date if requested.*

If a subscriber is enrolled in a Medicare Advantage plan, then a Medicare Advantage Plan Disenrollment Form *(Form D) is required. The effective date of the deferral is prospective from the date the PEBB Program receives both Form D and Form E.*

(continued)

2019 Retiree Coverage Change Form

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

Section 3: Spouse or state-registered domestic partner information

See attached instruction sheet for more information.

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

Street address Apt./unit number	City	State	ZIP Code

A. Relationship to subscriber ❑ Spouse: date of marriage ___________
❑ State-registered domestic partner: date registered ___________

Date of birth (mm/dd/yyyy)

B. Coverage for spouse or state-registered domestic partner

❑ Add to coverage. If adding a state-registered domestic partner, also attach a completed *Declaration of Tax Status* form and proof of dependent eligibility within PEBB's enrollment timelines. Effective date ___________

❑ Remove from coverage. Attach a copy of divorce decree or dissolution of state-registered domestic partnership if removing for this reason. Effective date ___________ Reason ___________

C. Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. If you check YES or leave this section blank (if enrolling a dependent), **you will be charged the $50 premium surcharge in addition to your monthly premium.** See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The surcharge does not apply.

❑ **YES, I am a non-Medicare subscriber and am subject to the $50 premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and completed the 2019 Spousal Plan Calculator.

❑ **NO, I am not a non-Medicare subscriber and am subject to the $50 premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and if needed, completed the 2019 Spousal Plan Calculator online.

Which questions (if any) on the 2019 *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

❑ I am completing and submitting the 2019 Spousal Plan Calculator found at **www.hca.wa.gov/erb** for the PEBB Program to determine.

Section 4: Dependent information *See attached instruction sheet for more information.*

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

Relationship to subscriber	Date of birth (mm/dd/yyyy)	❑ Child ❑ Stepchild (not legally adopted) ❑ Extended dependent (attach copy of court order)	❑ Disabled (check only if age 26 or older)

Street address Apt./unit number	City	State	ZIP Code

Coverage for dependent
❑ Add to coverage. Effective date ___________
❑ Remove from coverage. Effective date ___________ Reason ________________________

2

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

Relationship to subscriber	Date of birth (mm/dd/yyyy)	❑ Child ❑ Stepchild (not legally adopted) ❑ Extended dependent (attach copy of court order)	❑ Disabled (check only if age 26 or older)

Street address Apt./unit number	City	State	ZIP Code

Coverage for dependent
❑ Add to coverage. Effective date ___________
❑ Remove from coverage. Effective date ___________ Reason ________________________

(continued)

2019 Retiree Coverage Change Form

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

Section 5: Medicare enrollment *See attached instruction sheet for more information.*

Subscriber	Spouse/state-registered domestic partner	Dependent 1	Dependent 2
A. Enrolled in Medicare Part(s) A (hospital) and/or Part B (medical)?*			
Part A ❑ Yes ❑ No Effective date ________ Part B ❑ Yes ❑ No Effective date ________	Part A ❑ Yes ❑ No Effective date ________ Part B ❑ Yes ❑ No Effective date ________	Name: ________________ Part A ❑ Yes ❑ No Effective date ________ Part B ❑ Yes ❑ No Effective date ________	Name: ______________ Part A ❑ Yes ❑ No Effective date ________ Part B ❑ Yes ❑ No Effective date ________
B. Enrolled in Medicare Part D (prescription drug coverage)? If yes, you may only enroll in Premera Blue Cross Medicare Supplement Plan F.			
Part D ❑ Yes ❑ No Effective date ________	Part D ❑ Yes ❑ No Effective date ________	Part D ❑ Yes ❑ No Effective date ________	Part D ❑ Yes ❑ No Effective date ________
C. Enrolled in Medicaid with Medicare Part D?			
❑ Yes ❑ No Effective date ________	❑ Yes ❑ No Effective date ________	❑ Yes ❑ No Effective date ________	❑ Yes ❑ No Effective date ________
D. Receiving Social Security Disability?			
❑ Yes ❑ No Effective date ________	❑ Yes ❑ No Effective date ________	❑ Yes ❑ No Effective date ________	❑ Yes ❑ No Effective date ________

*If yes, proof is required. Attach a copy of your or your dependent's Medicare card (or all pages of the entitlement letter) to this form if we don't already have a copy. Write your full name and last four digits of your Social Security number on the copy.

Section 6: Tobacco use premium surcharge *See attached instruction sheet for more information.*

The PEBB Program requires a monthly $25-per-account monthly surcharge in addition to your monthly premium if you are **not** enrolled in Medicare Part A and Part B and you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. Only complete this section if you are not enrolled in Medicare Part A and Part B. **If you check YES or leave this section blank** for you and any enrolled dependents, you will be charged the premium surcharge. See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

Subscriber	Spouse /state-registered domestic partner	Dependent 1	Dependent 2
❑ **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 the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.	❑ **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 enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.	Name__________________ ❑ **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 the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.	Name__________________ ❑ **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 the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.

(continued)

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

Section 7: Special open enrollment (SOE) changes *See attached instruction sheet for more information.*

The PEBB Program only allows changes outside of an annual open enrollment when an event creates a special open enrollment (SOE). The change must be allowable under the Internal Revenue Code and Treasury regulations, and correspond to and be consistent with a special open enrollment event for the subscriber, the subscriber's dependents, or both. The PEBB Program must receive Form E and proof of the event that created the special open enrollment **no later than 60 days after the event occurs**.

A. Changes you can make if an event creates a special open enrollment

Check the box next to each change you are requesting, and indicate the corresponding event(s) below.

- ❑ Add dependent(s)
- ❑ Change medical and/or dental plans   Date of change _______________

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.

B. The following events allow a subscriber to add a dependent and change a medical or 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 becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form, available at **www.hca.wa.gov/erb**.
- ❑ Subscriber or subscriber's dependent losing other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ❑ Subscriber having a change in employment status that affects their eligibility for the 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 requiring the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ❑ Subscriber or dependent becoming entitled to or losing eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ Subscriber or dependent becoming eligible for a state premium assistance subsidy for PEBB Program health plan coverage from Medicaid or CHIP.

C. The following events allow a subscriber to add a dependent:

- ❑ Dependent having a change in enrollment under an 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 moving from outside of the United States to within the United States, or from within the United States to outside of the United States.

D. The following events allow medical and/or dental plan changes:

- ❑ Subscriber or dependent having a change in residence that affects health plan availability.
- ❑ Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).
- ❑ Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare, or enrolling (or terminating enrollment) in a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).

(continued)

2019 Retiree Coverage Change Form

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

Section 8: Medical plan selection *See attached instruction sheet for more information.*

Kaiser Foundation Health Plan of the Northwest[7]

- ❑ Kaiser Permanente NW Classic[8]
- ❑ Kaiser Permanente NW Consumer-Directed Health Plan[4,8]
- ❑ Kaiser Permanente NW Senior Advantage[1]

Kaiser Foundation Health Plan of Washington[7]

- ❑ Kaiser Permanente WA Classic
- ❑ Kaiser Permanente WA Consumer-Directed Health Plan[4]
- ❑ Kaiser Permanente WA Medicare Plan[1,2]
- ❑ Kaiser Permanente WA SoundChoice[3, 10]
- ❑ Kaiser Permanente WA Value[3]

❑ **Premera Blue Cross Medicare Supplement Plan F**[5]

Uniform Medical Plan, administered by Regence BlueShield

- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan[4]

UMP Plus (select a network)

- ❑ UMP Plus–Puget Sound High Value Network[6,7,9]
- ❑ UMP Plus–UW Medicine Accountable Care Network[6,7]

1. These Medicare Advantage plans are available in certain counties to Medicare enrollees. Also complete and attach Form C if you live in a county where Medicare Advantage is available.
2. If you cover dependents not enrolled in Medicare Part A and Part B, you may also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.
3. This plan is available only if at least one 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.
4. 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 coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.
5. Also complete and return Form B to enroll in Premera Blue Cross Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.
6. This plan is not available to Medicare Part A and Part B retirees and their dependents.
7. 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.
8. Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.
9. This plan does not have network primary care providers for adults in Thurston County.
10. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

Section 9: Dental plan selection *See attached instruction sheet for more information.*

You must enroll in medical coverage to enroll in dental. If you enroll in dental, you must remain enrolled for at least two years. Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans, not your dentist, for benefits information. 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 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.

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2019 Retiree Coverage Change Form

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

Section 10: Payment authorization *See attached instruction sheet for more information.*	
How would you like to pay your medical, dental, and life insurance premiums (if elected) and any applicable premium surcharges?	**How to make payments**
❑ **I want to keep the same payment method I currently have** ❑ **I want to change my payment method (check box below)**	
❑ **Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and any applicable premium surcharges I am required to pay from my retirement pension. Deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.	If you select pension deduction, the PEBB Program will send you an invoice if payment is needed. You will receive an invoice and must pay by check until your pension deduction is set up.
❑ **Invoicing:** I will pay my medical and dental (if elected) premiums and any applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. ❑ **Electronic Debit Service (EDS):** I will complete and submit the *Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. I will pay my monthly premium(s) and any applicable premium surcharges by check until notified of my EDS effective date.	If you select one of the options at the left for your medical and dental premium with any applicable surcharges, make your check payable to **Health Care Authority.** Send it (with your EDS form, if elected) to: Washington State Health Care Authority PO Box 42691 Olympia, WA 98504-2691

(continued)

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

Section 11: Signature

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) or premiums paid on my behalf. 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 knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime and can result in imprisonment, fines, and denial of PEBB benefits.

If I send payment, this does not mean I will be automatically enrolled in PEBB retiree insurance coverage. The PEBB Program will verify eligibility for me and my dependents. If we do not qualify, I will receive a refund of premium payments.

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 not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, I must remain enrolled in retiree dental for at least two years unless I defer coverage as described in Section 1, or enroll in employer-based group dental insurance or such coverage under COBRA or continuation coverage as an employee or dependent of an employee.

I also understand that it is my responsibility to verify my dentist is covered by the dental plan network I selected.

I understand if I or any enrolled dependent are entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.

If I choose to defer medical/dental, I understand I can enroll or reenroll no later than 60 days after losing other qualifying medical coverage or during the PEBB Program's annual open enrollment period (November 1-30) as long as there has been no gap in qualifying coverage and I provide proof of continuous enrollment in qualifying medical coverage. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or the last day of the PEBB Program's annual open enrollment period. If I defer enrollment for myself, I cannot enroll my eligible dependents except as allowed under PEBB rules. I understand in most cases, enrollment will be deferred effective the first of the month following the date this form is received by the PEBB Program unless a future date is provided.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand the PEBB Program will direct a portion of my monthly premium to an HSA 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 die, my eligible surviving dependents must complete the *Retiree Coverage Election Form* (Form A) to enroll or defer enrollment in PEBB retiree health insurance coverage. The PEBB Program must receive the form no later than 60 days after my death.

This form replaces all *Retiree Enrollment or Change Forms* previously submitted to the PEBB Program. If I am a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with DRS to better serve me.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

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/erb.

Be sure to sign and date this form and keep a copy for your records.
Mail completed form and documentation to:
Washington State Health Care Authority, PEBB Program, PO Box 42684, Olympia, WA 98504-2684 **or fax to:** 360-725-0771
Questions? Visit our website at **www.hca.wa.gov/pebb-retirees** or call us at 1-800-200-1004.

Subscriber's signature ____ Date ________________

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

2019 PEBB Medical Contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101-1374
In 2018: 1-888-901-4636 **In 2019:** 1-866-648-1928
or TTY 1-800-833-6388

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 Avenue, Suite 235, Seattle, WA 98101
1-888-849-3681 or TRS 711

2019 PEBB Dental Contractors

DeltaCare,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800, Seattle, WA 98109-5371

Uniform Dental Plan,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800, Seattle, WA 98109-5371
1-800-537-3406

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

Retiree Coverage Change Form (Form E) instructions

All forms and documents mentioned here are available at **www.hca.wa.gov/pebb-retirees** under *Forms & publications.*

Note: If you are newly eligible and applying to enroll or defer enrollment in Public Employees Benefits Board (PEBB) retiree insurance coverage, or requesting to enroll after deferring, **please complete the *Retiree Coverage Election Form* (Form A).**

Before you begin

Use these instructions to complete Form E. The form must be typed or printed clearly in dark ink. **Do not return these instructions** with Form E. **Form E replaces all enrollment or change forms previously submitted.**

Timelines to make changes

The timeframe you have to make changes to your account depends on the type of change you need to make. For example, you can remove a dependent at any time during the year. However, certain changes can only be made within a limited time after an event that creates a special open enrollment — like a marriage or becoming eligible for Medicare.

To learn more about your timeline to make changes, see the *Retiree Enrollment Guide* or visit **www.hca.wa.gov/pebb-retirees** and click on *Change your coverage*. If you have had an event that created a special open enrollment, the PEBB Program must receive Form E and any other required documents **no later than 60 days** after the event that created your special open enrollment.

Additional forms or documents you may need to complete and submit with Form E

- If changing your medical plan to Premera Blue Cross Medicare Supplement Plan F, you must also complete and submit the *Group Medicare Supplement Enrollment Application* **(Form B).**
- If changing your medical plan to a Medicare Advantage plan, you must also complete and submit the *Medicare Advantage Plan Election Form* **(Form C).**
- If terminating coverage for you or a dependent, or changing medical plans while you or a dependent are enrolled in a Medicare Advantage plan, you must also complete and submit the *PEBB Medicare Advantage Plan Disenrollment Form* **(Form D).**
- If enrolling a state-registered domestic partner or the partner's child, you must also complete and submit the *Declaration of Tax Status form*.
- If enrolling a dependent with a disability age 26 or older, you must also complete and submit the *Certification of Dependent with a Disability* form and return as instructed on the form.
- If enrolling an extended dependent, you must also complete and submit the *Extended Dependent Certification* form.

Note: If making a change due to a special open enrollment event, you must also provide proof of the event that created the special open enrollment.

Submit dependent verification documents if:

- You (the subscriber) are **not** enrolled in Medicare Part A and Part B and are enrolling a dependent.
- You are enrolling a state-registered domestic partner and/or their dependents.

A list of documents we will accept to verify your dependent's eligibility is available in the *Retiree Enrollment Guide* or at **www.hca.wa.gov/pebb-retirees**.

How to submit your completed enrollment form(s) and documentation

Mail to	Washington State Health Care Authority PEBB Program PO Box 42684 Olympia, WA 98504-2684
Fax to:	360-725-0771
Electronically submit:	Send a secure online message to PEBB Customer Service by registering for an account at **www.fuzeqna.com/pebb/consumer/question.asp.** **Note:** You must sign and date any forms you attach to a secure online message.

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How to complete the *Retiree Coverage Change Form* (Form E)

After you complete each section of the form that applies to you, check it off. Do not return the checklist below with your Form E.

❑ Section 1: Subscriber information

Print your (the retiree's) information in this section.

❑ Section 2: Changes to an existing retiree account

Complete the section(s) that describe the type of change you are making. If you (the subscriber) are terminating or deferring, you only need to complete sections 1, 2, and 11.

A. Terminate: If you are terminating, check the appropriate box. **Important:** If you terminate your PEBB retiree health plan, you cannot enroll again later unless you regain eligibility for PEBB coverage. To terminate your retiree term life insurance, call MetLife at 1-866-548-7139.

B. Defer: If you are deferring coverage, check the appropriate box and identify the reason for deferral. In most cases, the deferral date will be prospective from the date the PEBB Program receives Form E. For information about deferring, see the *Retiree Enrollment Guide* or visit **www.hca.wa.gov/pebb-retirees** and click on *Defer retiree coverage*.

❑ Section 3: Spouse or state-registered domestic partner information

Only complete this section if you want to cover or remove coverage for your spouse or state-registered domestic partner (as defined in WAC 182-12-260(2)).

All subscribers: If adding a state-registered domestic partner, also attach a completed *Declaration of Tax Status* form and proof of the dependent's eligibility.

Non-Medicare subscribers only: If adding a spouse, you must provide proof of your spouse's eligibility before we can enroll them.

Follow the directions to complete each subsection below and attest to the premium surcharge.

A. Relationship to subscriber. Check the box that appropriately describes the relationship.

B. Coverage for spouse or state-registered domestic partner. Check the appropriate box for coverage. Indicate date and reason.

C. Spouse or state-registered domestic partner coverage premium surcharge. Answer these questions if you are **not** enrolled in Medicare Part A and Part B (Non-Medicare) and are covering a spouse or state-registered domestic partner.

- The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B (non-Medicare), and your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic.
- For help determining whether you will be charged the spouse or state-registered domestic partner coverage premium surcharge, see the *Premium 2019 Surcharge Help Sheet* in the back of the *Retiree Enrollment Guide*. You can also visit **www.hca.wa.gov/pebb-retirees** and click on *Surcharges* for more information.

❑ Section 4: Dependent information

Only complete this section if you want to cover or remove coverage for eligible dependents, including children as defined in WAC 182-12-260(3). Dependents cannot be enrolled on two PEBB medical or dental accounts at a time.

Non-Medicare subscribers: If you are enrolling dependents, you must also provide proof of eligibility for each dependent within PEBB's enrollment timelines.

- If adding a **state-registered domestic partner's child,** also complete and submit the *Declaration of Tax Status* form and proof of the dependent's eligibility.
- If adding a **dependent with a disability** age 26 or older, also complete and submit the *Certification of Dependent with a Disability* form and return as instructed on the form.
- If adding an **extended dependent,** also complete and submit the *Extended Dependent Certification* form.

❑ Section 5: Medicare enrollment information

Check the appropriate boxes to indicate the Medicare enrollment status for you and any newly enrolled dependents. Respond to the following questions:

A. Enrolled in Medicare Part(s) A and/or B? If yes, proof is required. If we don't already have a copy of your or your dependent's Medicare card, attach a copy of the card **or** a copy of all pages of the entitlement letter to Form E. Write your full name and last four digits of your Social Security number on the copy.

B. Enrolled in Medicare Part D (prescription drug coverage)? If yes, you may only enroll in Premera Blue Cross Medicare Supplement Plan F.

C. Enrolled in Medicaid with Medicare Part D?

D. Receiving Social Security Disability?

❑ Section 6: Tobacco use premium surcharge

Only complete this section if you are not enrolled in Medicare Part A and Part B (Non-Medicare). You only need to complete this section if you are changing an existing attestation or are enrolling new dependents. Responses are only required for dependents age 13 or older.

The PEBB Program requires a monthly $25-per-account premium surcharge in addition to your monthly premium if you are **not** enrolled in Medicare Part A and Part B and you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. **If you check YES or leave this section blank** for you and any enrolled dependents, you will be charged the premium surcharge. See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

❑ Section 7: Special open enrollment changes

The PEBB Program only allows changes outside of an annual open enrollment when an event creates a special open enrollment. The PEBB Program must receive Form E and proof of the event that created the special open enrollment **no later than 60 days after the event occurs.** To learn more, see pages 24-27 of the *Retiree Enrollment Guide* or visit **www.hca.wa.gov/pebb-retirees** and click on *Change your coverage.*

❑ Section 8: Medical plan selection

Check the box for the medical plan you are eligible for and wish to enroll in. You may be required to submit additional forms, which are listed in the right column of Section 8.

❑ Section 9: Dental plan selection

Only complete this section if you are enrolling in dental coverage. You must enroll in medical coverage to enroll in dental.

- If you select dental coverage for yourself, **you must keep dental coverage for yourself and any enrolled dependents for at least two years** unless you defer or terminate enrollment as described in PEBB Program rules (WA 182-12-208).
- Before you select a dental plan, call the plan, not your dentist, to make sure your provider participates with the plan.

❑ Section 10: Payment authorization

Choose a payment method, even if you aren't changing the method you currently use. If you choose Electronic Debit Service (EDS), also complete and submit the *Electronic Debit Service Agreement* form. Mail your **payment and the EDS form, if elected,** to the address listed in this section.

❑ Section 11: Signature

Read Section 11 carefully to understand your responsibilities for Form E. Then sign and date this section to complete your enrollment form. **Mail Form E and any other required forms** to the address listed in this section.