Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Retiree Coverage Change Form

E

Complete this form to make changes to an existing retiree account. If you are newly eligible and applying to enroll in or defer PEBB retiree insurance coverage, or enrolling after deferring, please complete the *2020 PEBB Retiree Coverage Election Form* (form A).

Remember to read and sign Section 8 on page 9. To enroll or remove dependents, fill out Section 9 starting on page 10. This form replaces all retiree enrollment/change forms submitted in the past.

Type or print clearly in dark ink, use only capital block lettering inside the boxes as shown in the example. Inaccurate, incomplete, or illegible information may delay coverage. Follow example to fill in form:

J O H N

Section 1 Subscriber information

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex

M F

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP Code

County of residence

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP Code

Continued on next page.

Subscriber's last name

Subscriber's Social Security number

Section 1 Subscriber information *(continued)*

Are you enrolled in Part(s) A and/or B of Medicare? If **Yes**, proof is required. Attach a copy of all pages of your entitlement letter or a copy of your Medicare card to this form if we don't already have a copy. Write your full name and the last four digits of your Social Security number on the copy. If you are entitled to Medicare, you must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Part A (hospital) Yes No If yes, effective date / /

Part B (medical) Yes No If yes, effective date / /

Are you enrolled in Medicare Part D (prescription drug coverage)? If **Yes**, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Yes No If yes, effective date / /

Are you enrolled in Medicaid with Medicare Part D?

Yes No If yes, effective date / /

Do you receive Social Security Disability?

Yes No If yes, effective date / /

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

Subscriber's last name

Subscriber's Social Security number

Section 2 Terminating or deferring coverage *See instructions for more information.*

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

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

☐ Medical coverage and dental coverage (if enrolled in both) for myself and any enrolled dependents. I understand I am forfeiting all further rights to enroll again unless I regain eligibility.

Termination date __ / __ / ____

☐ Dental coverage for myself and any enrolled dependents. 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 or terminating from my PEBB retiree health plan coverage as allowed under PEBB Program rules (see Section 8).

Termination date __ / __ / ____

B. Defer:

☐ Defer (postpone) my coverage*

Except as stated below, this defers coverage for all enrolled dependents. Deferral date __ / __ / ____
**Deferral is prospective from the date this form is received (or a future date if you requested it).*

If deferring, check the box below that applies to you. You must provide proof of continuous enrollment in one or more qualifying coverages from the date of deferral (with start and end dates) when you return to a PEBB retiree health plan.

☐ Enrolled in a PEBB Program, a Washington State educational service district, or a School Employees Benefits Board (SEBB) Program sponsored health plan as a dependent. This includes coverage under COBRA or continuation coverage.

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

☐ Enrolled in medical coverage as a retiree or dependent of a retiree in a TRICARE plan 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.

☐ Enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). You have a one-time opportunity to enroll in a PEBB retiree health plan.

☐ **Non-Medicare retirees:** Enrolled in qualified health plan coverage through a health benefit exchange, not including Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

If you are enrolled in a Medicare Advantage plan, then a *2020 PEBB 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.

Subscriber's last name

Subscriber's Social Security number

Section 3 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.

Non-Medicare subscribers: If enrolling a spouse, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. **All subscribers:** If enrolling a state-registered domestic partner, please also attach proof of eligibility and a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b). A list of documents we will accept to verify their eligibility is available at **hca.wa.gov/pebb-retirees**.

Relationship to subscriber

Spouse: date of marriage / /

State-registered domestic partner: date registered / /

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy) / /

Social Security number

Sex

M F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Coverage for spouse or state-registered domestic partner

Cover

Remove Attach a copy of divorce decree or dissolution of state-registered domestic partnership if removing them for this reason
If yes, effective date / /

Does this person receive Social Security Disability?

Yes No
If yes, effective date / /

Is this person enrolled in Part(s) A and/or B of Medicare? If **Yes**, proof is required. Attach a copy of all pages of their entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. If they are entitled to Medicare, they must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Part A (hospital) Yes No
If yes, effective date / /

Part B (medical) Yes No
If yes, effective date / /

Is this person enrolled in Medicare Part D (prescription drug coverage)? If **Yes**, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Yes No
If yes, effective date / /

Is this person enrolled in Medicaid with Medicare Part D?

Yes No
If yes, effective date / /

Subscriber's last name

Subscriber's 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 $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** 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.** 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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to PEBB's Uniform Medical Plan Classic. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**. If you check **Yes** below or leave this section blank, you will be charged the $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 PEBB Spousal Plan Calculator* at **hca.wa.gov/pebb-retirees**.
- **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 PEBB Spousal Plan Calculator*. 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
- **The 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*.

To add dependents, continue to section 9 on page 10.

Subscriber's last name

Subscriber's Social Security number

Section 4 Special open enrollment (SOE) changes *See instructions 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 PEBB Program must receive Form E and proof of the event that created the SOE **no later than 60 days** after the event occurs.

A. Changes you can make if an event creates an SOE

Check the box next to each change you are requesting, and indicate the corresponding event(s) below. 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. If that day is the first of the month, the change begins on that day.

- ☐ Enroll dependent(s)
- ☐ Change medical and/or dental plans

Date of change: ___ / ___ / ______

B. The following events allow a subscriber to enroll a dependent and change a medical or dental plan:

- ☐ Marriage, registering a domestic partnership (as defined by Washington Administrative Code 182-12-109), 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 a *2020 PEBB Extended Dependent Certification* form, available at **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:

- ☐ Subscriber or 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, and the move resulted in the dependent losing their health insurance.

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 for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).
- ☐ Subscriber or dependent 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).

Subscriber's last name

Subscriber's Social Security number

Section 5 Medical plan selection *See instructions for more information.*

- [ ] I wish to continue enrollment in my current medical plan.

Kaiser Foundation Health Plan of the Northwest[1]

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

Kaiser Foundation Health Plan of Washington[1]

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

Premera Blue Cross

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

Uniform Medical Plan, administered by Regence BlueShield

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

[1] These plans have specific service areas. If you move out of the service area, you must change your plan. Otherwise, you will have limited access to network providers and covered services. You must notify the PEBB Program no later than 60 days after you move.

[2] Kaiser Foundation Health Plan of the Northwest 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 enrollees. Also complete and attach Form C if you live in a county where Medicare Advantage is available.

[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 their PEBB coverage to enroll in this plan. They 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 member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA Medicare Plan.

[8] Also submit Form B to enroll in Premera Blue Cross Medicare Supplement Plan G.

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
1-800-813-2000 or TRS: 711
Medicare members: 1-877-221-8221

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388
Medicare members: 1-888-901-4600

Premera Blue Cross
PO Box 327, Seattle, WA 98111
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, *administered by Regence BlueShield*
1800 Ninth Avenue, 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
1-855-4DENTAL (1-855-433-6825)

Subscriber's last name

Subscriber's Social Security number

Section 6 **Dental plan selection** *See instructions for more information.*

You must enroll in medical coverage to enroll in dental. If you enroll in dental, 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 (WAC 182-12-208). However, you may change dental plans within those two years during the PEBB Program's annual open enrollment (November 1 through 30) or due to a special open enrollment event. Before you select a dental plan, call the plan to make sure your provider accepts the specific plan and plan group.

- [ ] **I wish to continue enrollment in my current dental plan.**

I wish to change my dental plan to:
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.

- [ ] **Willamette Dental of Washington, Inc.** (Group WA82), administered by Willamette Dental Group. You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan.

Section 7 **Payment authorization** *See instructions for more information.*

How would you like to pay your premiums and applicable premium surcharges?

- [ ] I wish to continue my current payment method.

I wish to change my payment method to:

- [ ] **Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental (if elected) premiums and applicable premium surcharges 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.
- [ ] **Electronic Debit Service (EDS):** I will submit the *2020 PEBB Electronic Debit Service Agreement* available at **hca.wa.gov/pebb-retirees**. I will pay my monthly medical and dental (if elected) premiums and applicable premium surcharges by check until notified of my EDS effective date.
- [ ] **Invoicing:** I will pay my medical and dental (if elected) premiums and applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected.

If you are currently enrolled in retiree term life insurance, your payment method will remain the same. Contact MetLife at 1-866-548-7139 for other payment options.

Note: Premiums and applicable premium surcharges are for a full month of coverage and cannot be prorated for any reason, including when a member dies or terminates coverage before the end of the month. Payments are processed immediately as required by state law.

Subscriber's last name

Subscriber's Social Security number

Section 8 Signature

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) 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 it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, which can result in imprisonment, fines, and denial of PEBB benefits.

If I send payment, this does not mean my change request will be approved. The PEBB Program will verify special open enrollment 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 the 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 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 terminate or defer PEBB retiree health plan coverage as described in Section 2, 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 through 30) as long as there has been no gap in qualifying coverage and I provide proof of continuous enrollment. 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 *2020 PEBB Retiree Coverage Election Form* (Form A) to enroll or defer enrollment in PEBB retiree health plan coverage. The PEBB Program must receive the form no later than 60 days after my death.

This form replaces all enrollment or change forms previously submitted to the PEBB Program. If I am a retiree or survivor 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 **hca.wa.gov/pebb-retirees**.

Subscriber's signature

Date / /

Please sign, date, and keep a copy for your records. Mail the completed form and documentation to the Washington State Health Care Authority, PEBB Program, PO Box 42684, Olympia, WA 98504-2684, or fax to 360-725-0771.

Subscriber's last name

Subscriber's Social Security number

Section 9 Dependent information *See instructions for more information.*

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability (age 26 or older)

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex M F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Coverage for dependent Cover Remove from coverage

Is this person enrolled in Part(s) A and/or B of Medicare?
If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) Yes No

If yes, effective date

Part B (medical) Yes No

If yes, effective date

If your dependent is entitled to Medicare, they must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes No

If yes, effective date

Is this person enrolled in Medicaid with Medicare Part D?

Yes No

If yes, effective date

Does this person receive Social Security Disability?

Yes No

If yes, effective date

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

Tobacco use premium surcharge
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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Subscriber's Social Security number

Section 9 Dependent information *See instructions for more information.*

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability (age 26 or older)

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex M F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Coverage for dependent Cover Remove from coverage

Is this person enrolled in Part(s) A and/or B of Medicare?
If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) Yes No

If yes, effective date

Part B (medical) Yes No

If yes, effective date

If your dependent is entitled to Medicare, they must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes No

If yes, effective date

Is this person enrolled in Medicaid with Medicare Part D?

Yes No

If yes, effective date

Does this person receive Social Security Disability?

Yes No

If yes, effective date

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

Tobacco use premium surcharge
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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

2020 PEBB Retiree Coverage Change Form

Subscriber's last name

Subscriber's Social Security number

Section 9 Dependent information *See instructions for more information.*

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability (age 26 or older)

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex

M F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Coverage for dependent Cover Remove from coverage

Is this person enrolled in Part(s) A and/or B of Medicare?
If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) Yes No

If yes, effective date

Part B (medical) Yes No

If yes, effective date

If your dependent is entitled to Medicare, they must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes No

If yes, effective date

Is this person enrolled in Medicaid with Medicare Part D?

Yes No

If yes, effective date

Does this person receive Social Security Disability?

Yes No

If yes, effective date

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

Tobacco use premium surcharge
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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Instructions for Completing Form E

E

All forms and documents mentioned here are available at **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 *2020 PEBB Retiree Coverage Election Form* (form A).

! Remember to read and sign page 9. To enroll dependents, fill out section 9 starting on page 10.

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. This form replaces all enrollment or change forms you submitted in the past. **Therefore, you need to include even things that you are not changing.**

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 *2020 PEBB Retiree Enrollment Guide* or visit **hca.wa.gov/pebb-retirees** and click on *Change your coverage*. If you have an event that creates a special open enrollment, the PEBB Program must receive Form E and any other required documents no later than 60 days after the event. You must also provide proof of the event.

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

If you are enrolling...	You must also submit...
In Premera Blue Cross Medicare Supplement Plan G	*Group Medicare Supplement Enrollment Application* (form B)
In a Medicare Advantage plan	*2020 PEBB Medicare Advantage Plan Election Form* (form C)
A state-registered domestic partner, the partner's child, or an extended dependent	*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)
A dependent child with a disability age 26 or older	*2020 PEBB Certification of a Child With a Disability* form. Return it as instructed on the form.
An extended dependent	*2020 PEBB Extended Dependent Certification* form

When to submit dependent verification documents

- You (the subscriber) are not enrolled in Medicare Part A and Part B, and you are enrolling a dependent.
- You are enrolling a state-registered domestic partner or their dependents (regardless of your Medicare enrollment status).

A list of documents we will accept to verify your dependent's eligibility is available in the *2020 PEBB Retiree Enrollment Guide* or at **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 **hca.wa.gov/fuze-questions**. You must date any forms you attach to a secure message.

Section 1 Subscriber information

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

Medicare enrollment: Check the appropriate boxes to show your Medicare enrollment status.

Tobacco use premium surcharge: Only complete this section if you are **not** enrolled in Medicare Part A and Part B. You only need to complete this section if you are changing an existing attestation. If you check **Yes** or leave this section blank, you will be charged the premium surcharge. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**.

Section 2 Terminating or deferring coverage

Complete the section(s) that describe the type of change you are making. If you are terminating or deferring, you only need to complete sections 1, 2, and 8.

A. **Terminate:** If you are terminating, check this box. If you terminate your PEBB retiree health plan coverage, 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 *2020 PEBB Retiree Enrollment Guide* or visit **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 182-12-109). Dependents cannot be enrolled on two PEBB medical or dental accounts at a time.

Non-Medicare subscribers: If enrolling a spouse, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled.

All subscribers: If enrolling a state-registered domestic partner, please also attach proof of eligibility and a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b).

A list of documents we will accept for this purpose is available at **hca.wa.gov/pebb-retirees**.

Follow the directions on the next page to complete each subsection and attest to the premium surcharges.

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

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

Medicare enrollment: Check the appropriate boxes to indicate the Medicare enrollment status for your spouse or state-registered domestic partner.

Tobacco use premium surcharge: Only complete this section if you are **not** enrolled in Medicare Part A and Part B (non-Medicare). If you check **Yes** or leave this section blank, you will be charged the premium surcharge. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**.

Spouse or state-registered domestic partner coverage premium surcharge: For help determining whether this surcharge applies to you, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* in the back of the *2020 PEBB Retiree Enrollment Guide*. You can also visit **hca.wa.gov/pebb-retirees** and click on *Surcharges* for more information.

Section 4 Special open enrollment (SOE) changes

The PEBB Program only allows changes outside of an annual open enrollment when an event creates an SOE. The change must be allowable under the Internal Revenue Code and Treasury regulations, and correspond to and be consistent with an SOE event. 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 the *2020 PEBB Retiree Enrollment Guide* or visit **hca.wa.gov/pebb-retirees** and click on *Change your coverage*.

Section 5 Medical plan selection

Check the box for the medical plan you are eligible for and wish to enroll or continue your enrollment in. You may be required to submit additional forms, which are listed in the right column of Section 5. Contact the plans with questions about benefits and providers.

Section 6 Dental plan selection

Only complete this section if you are enrolling in dental coverage or wish to continue enrollment in your current plan. 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 (WAC 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 7 Payment authorization

Choose to keep your current payment method or select a new one. If you choose Electronic Debit Service (EDS), also submit the *2020 PEBB Electronic Debit Service Agreement*. Mail your payment and the EDS form to the address listed in this section. If you choose pension deduction, the deduction will be taken at the end of the month in which you receive coverage. For example, if your coverage starts May 1, the deduction will be taken at the end of May.

Section 8 Signature

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

Section 9 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 enrolling a dependent, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled.

All subscribers: If enrolling a state-registered domestic partner's child or an extended dependent, please also attach proof of eligibility and a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b).

If adding a **dependent child with a disability age 26 or older**, also submit the *2020 PEBB Certification of a Child with a Disability* form.

If adding an **extended dependent**, also submit the *2020 PEBB Extended Dependent Certification* form.

Medicare enrollment: Check the appropriate boxes to indicate the Medicare enrollment status for your dependent.

Tobacco use premium surcharge: Only complete this section if you are a non-Medicare subscriber. Responses are only required for dependents age 13 or older. If you check **Yes** or leave this section blank, you will be charged the premium surcharge. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**.