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Clear form

2021 **PEBB Retiree Change Form**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

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 *PEBB Retiree Election Form* (form A).

This form replaces all enrollment forms previously submitted. Therefore, you must complete the entire form, including the dependent section for any children you want to continue to cover. All forms and documents mentioned are available on HCA's website at **hca.wa.gov/pebb-retirees** under *Forms & publications*.

Type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example: J O H N

Inaccurate, incomplete, or illegible information may delay coverage.

Remember to read and sign Section 8. To enroll children, complete Section 9 on pages 11 and 12.

1 Subscriber

Social Security number

Date of birth

Sex assigned at birth[1]

Male Female

Last name

Gender identity[2]

Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

1 *This field is required for health care services.*

2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Are you enrolled in Medicare Part A or Part B?

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

If **Yes,** proof is required. Attach a copy of all pages of your entitlement letter or a copy of your Medicare card to this form if we don't already have a copy. If you are eligible for Medicare, you must enroll and stay enrolled in both Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Are you enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If **Yes,** you may enroll only in one of the UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans or Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Are you enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

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

Tobacco use premium surcharge

If you need to report a change to your previous tobacco surcharge attestation, you can do it online through PEBB My Account at **hca.wa.gov/my-account** or submit the *2021 PEBB Premium Surcharge Attestation Change Form*, available on HCA's website at **hca.wa.gov/pebb-retirees**.

Subscriber's last name

Social Security number

2 Terminate or defer coverage

If you are terminating or deferring your coverage, you only need to complete Sections 1, 2, and 8. To terminate retiree term life insurance, call MetLife at 1-866-548-7139.

A. Terminate coverage: I am enrolled in PEBB retiree insurance coverage. I want to:

Terminate medical 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. I understand I must also complete Form D if I or an enrolled dependent are in a Medicare Advantage plan.

Termination date:

Terminate dental coverage for myself and any enrolled dependents.
I understand that I may only terminate this coverage if I have been enrolled in a PEBB retiree dental plan for at least two years, or if I am deferring or terminating my PEBB coverage as allowed under PEBB Program rules (see Section 8).

Termination date:

B. Defer:

Defer (postpone) my coverage

Deferral date:

Deferral is prospective from the date this form is received (or a future date if you requested it). Except as stated below, this defers coverage for all enrolled dependents. **Check the box below that applies to you.** Keep in mind that when you enroll after deferring, you must provide proof of continuous enrollment in one or more qualifying coverages since your date of deferral.

Enrolled in a PEBB Program, a Washington State educational service district, or 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 subscribers 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.

If you or an enrolled dependent are in a Medicare Advantage plan, then you must also submit a *2021 PEBB Medicare Advantage Plan Disenrollment Form* (form D) with this form. 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

Social Security number

3 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or state-registered domestic partner (SRDP), as defined by WAC 182-12-109, you wish to cover or remove from coverage. To enroll children, please complete Section 9, located at the end of the form.

Relationship to subscriber

Spouse: date of marriage

SRDP: date registered

Social Security number

Date of birth

Sex assigned at birth[1]

Male Female

Last name

Gender identity[2]

Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber's)

Address line 2

City

State

ZIP/Postal code

County

Coverage for spouse or SRDP

Cover

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 SRDP, you must attach proof of eligibility and a *PEBB Declaration of Tax Status* 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 prove their eligibility is available on HCA's website at **hca.wa.gov/pebb-retirees**.

Remove from coverage

Attach a copy of divorce decree or dissolution of state-registered domestic partnership if removing for this reason.

Effective date:

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

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

If **yes,** proof is required. Attach a copy of all pages of their entitlement letter or a copy of their Medicare card to this form 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 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.

1 *This field is required for health care services.*

2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

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

Yes No If Yes, effective date:

If **yes**, you may enroll only in one of the UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans or Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Is this person enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

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

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The PEBB Program requires a monthly $25-per-account premium surcharge in addition to your monthly medical premium if you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months, except for religious or ceremonial use. If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the PEBB Program Administrative Policy 91-1 at **hca.wa.gov/pebb-rules**.

If you check Yes or do not check any boxes below, you will be charged the $25 premium surcharge. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* available on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

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

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

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

Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

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

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

Yes, I am subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *2021 PEBB Spousal Plan Calculator* online.

No, I am not subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *PEBB Spousal Plan Calculator* online. Which questions, if any, on the *PEBB Premium Surcharge Attestation Help Sheet* did you check No? **Check all that apply.** Question 1 is not applicable.

Question 2 Question 3 Question 4 Question 5 Question 6

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

Response required if you are enrolling your spouse or SRDP in medical coverage. The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic. **If you check Yes below or do not check any boxes below, you will be charged the $50 premium surcharge.** See the *2021 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

Subscriber's last name

Social Security number

4 Special open enrollment (SOE) changes

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 (SOE). The change must be allowable under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with an SOE event for the retiree, retiree's dependent, or both. To disenroll from a Medicare Advantage plan or Medicare Advantage Prescription Drug (MAPD) plan, the change must be allowed under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c).

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. Exceptions apply for new enrollment in a PEBB Medicare Supplement plan, Medicare Advantage, or MAPD plan.

Check the box next to the change you are requesting and the corresponding event. 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.

☐ Add dependents

☐ Change medical or dental plans Date of change:

The following events allow a subscriber to enroll dependents and change a medical or dental plan.

☐ Subscriber or 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 enrolls in or loses eligibility for coverage under 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.

☐ Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2021 PEBB Extended Dependent Certification* form and *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), available at **hca.wa.gov/pebb-retirees**.

☐ Marriage, registering a domestic partnership (as defined by Washington Administrative Code 182-12-109), birth, adoption, or assuming a legal responsibility for support in anticipation of adoption. If enrolling a state-registered domestic partner (SRDP) or their child, you must also submit a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section105(b).

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The following events allow a subscriber to enroll dependents.

- 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 another country to the United States, or from the United States to another country, and the move resulted in the dependent losing their health insurance.

The following events allow medical and 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 enrolling in Medicare or losing eligibility under Medicare, or enrolling (or terminating enrollment) in a Medicare Advantage Prescription Drug plan or 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).

2021 PEBB Program contractors

! Do not send forms to the addresses below. This information is for reference only.

Medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
1-866-648-1928 (TTY: 1-800-833-6388)

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

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Avenue, Suite 235
Seattle, WA 98101
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

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

Dental contractors

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-650-1583

Uniform Dental Plan,
administered by Delta Dental of Washington
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-537-3406 (TTY: 800-833-6384)

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-433-6825 (TTY: 711)

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Subscriber's last name

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5 Medical plan selection

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

UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)[9]

- UnitedHealthcare PEBB Balance
- UnitedHealthcare PEBB Complete

! Contact the plans with questions about benefits and provider information. (Contact information is on page 7 of this form.)

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

[2] Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

[3] These Medicare plans are available only in certain counties. See "Medical plans available by county" on HCA's website at **hca.wa.gov/pebb-retirees**. Submit Form C with this form if you live in a county where a Medicare Advantage plan is available.

[4] If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.

[5] These plans are available only if you and your enrolled dependents are not enrolled in Medicare.

[6] Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

[7] Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.

[8] Also submit Form B to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on the account will be enrolled in UMP Classic.

[9] Also submit Form C to enroll in these plans. They are only available to Medicare members. Any non-Medicare members on the account will be enrolled in UMP Classic.

Subscriber's last name

Social Security number

6 Dental plan selection

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.

I wish to continue enrollment in my current dental plan.

I wish to change my dental plan. **Select one plan below.**

I wish to terminate dental. I understand that I may only terminate this coverage if I have been enrolled in a PEBB retiree dental plan for at least two years, or if I am deferring or terminating my PEBB coverage as allowed under PEBB Program rules (see also Section 8). If I terminate dental for myself, dental is terminated for my enrolled dependents.

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 must select a primary care dentist in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to make sure your provider accepts the specific plan and plan group you choose.

Willamette Dental of Washington, Inc. (Group WA82), administered by Willamette Dental Group. You will select and receive services from a provider in the Willamette Dental Group Plan network. Before you enroll, call Willamette at 1-855-433-6825 to make sure your provider accepts the specific plan and plan group you choose.

7 Payment

How would you like to pay your medical, dental, and life insurance premiums (if elected) and applicable premium surcharges?

I wish to continue my current payment method.

I wish to change my payment method to:

Invoicing: I will pay my medical and dental premiums (if elected) and applicable premium surcharges monthly by check.

Electronic Debit Service (EDS): I will pay my monthly medical and dental premiums (if elected) and applicable premium surcharges by EDS. I will submit the *PEBB Electronic Debit Service Agreement* available on HCA's website at **hca.wa.gov/pebb-retirees**. I understand I must pay by check until I am notified of my EDS effective date.

Pension deduction: I authorize the Department of Retirement Systems (DRS) to deduct medical and dental premiums (if elected) and applicable premium surcharges that 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. Due to timing issues with DRS, you may receive an invoice for any premiums and applicable premium surcharges not deducted from your pension. The PEBB Program will send you an invoice if payment is needed until your pension deduction is set up.

If you are currently enrolled in retiree term life insurance, your payment method will remain the same. Call MetLife at 1-866-548-7139 for other payment options. Premiums and any applicable premium surcharges are for a full month of coverage and cannot be prorated for a partial month. Payments are processed immediately as required by state law.

Subscriber's last name

Social Security number

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 health plan coverage as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of PEBB benefits.

If I send payment, this does not mean 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 (SRDP) 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 dental, I must remain enrolled for at least two years unless I terminate or defer PEBB retiree insurance 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 eligible for Medicare Part A and Part B, we must enroll and stay 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 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 Program 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. 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 *PEBB Retiree Election Form* (form A) to enroll or defer enrollment in PEBB retiree insurance 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 Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my insurance coverage selections being rejected or defaulted.

Subscriber's signature

Date

Please sign, date, and keep a copy for your records. Submit form and documentation using one of the methods below:
Mail to: 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 on HCA's website at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

HCA is committed to providing equal access to our services. If you need an accommodation, please call the PEBB Program at 1-800-200-1004.

HCA's Privacy Notice: HCA will keep your information private as allowed by law. To see our Privacy Notice, go to HCA's website at **hca.wa.gov/pebb-retirees**.

Subscriber's last name

Social Security number

9 Dependents

List eligible dependents you wish to enroll or remove from coverage. Enrolled children must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and children age 26 or older with a disability. Use additional forms for more dependents.

Subscribers who are **not** enrolled in Medicare Part A and Part B must provide proof of eligibility for each dependent within the PEBB Program's enrollment timelines or the dependent will not be enrolled. A list of documents we will accept to verify dependent eligibility is available on HCA's website at **hca.wa.gov/pebb-retirees**.

If enrolling a state-registered domestic partner's (SRDP's) child, also attach a *2021 PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, also attach a *2021 PEBB Extended Dependent Certification*.

If enrolling a child with a disability age 26 or older, also attach a *2021 PEBB Certification of a Child with a Disability* and return as instructed. Visit HCA's website at **hca.wa.gov/pebb-retirees** for eligibility information.

Relationship to subscriber

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

Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.

Social Security number

Date of birth

Sex assigned at birth[1]

Male Female

Last name

Gender identity[2]

Male Female X

First name

Middle initial

Suffix

Street address (if different from subscriber's)

Address line 2

City

State

ZIP/Postal code

County

Coverage for dependent

Add to coverage

Effective date:

Remove from coverage

If removing from coverage, include reason:

1 *This field is required for health care services.*

2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

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

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

If **Yes,** proof is required. Attach a copy of all pages of their entitlement letter or a copy of their Medicare card to this form 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 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:

If **Yes**, you may enroll only in one of the UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans or Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Is this person enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

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

Tobacco use premium surcharge

Response required if you are enrolling a dependent age 13 or older in medical coverage. **If you check Yes or do not check any boxes below, you will be charged the $25 premium surcharge.** See the *2021 PEBB Premium Surcharge Attestation Help Sheet* available on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

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

Yes, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months. If this is a change to a previous attestation, submit the *PEBB Premium Surcharge Attestation Change Form*.

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

Use additional forms to list more dependents.