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2022 PEBB Medicare Advantage Plan Election Form

Clear form

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Please fill in all information requested. Be sure to read and sign section 4 on page 5 of this form. 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. The information written on this form replaces all enrollment forms previously submitted.

1 Retiree

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name (as it appears on Medicare card)

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (required)

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

Retiree Medicare number

Are you entitled to Medicare Part A or Part B?

Part A (hospital) Yes Effective date No

Part B (medical) Yes Effective date No

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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Retiree's last name

Social Security number

☐ Married Date

☐ State-registered domestic partnership/legal union Date

Retiree medical information

Your answers to question 3 below will not affect your eligibility to enroll in a Medicare Advantage plan.

1. **Do you have any health insurance other than Medicare?** ☐ Yes ☐ No
   If yes, through which carrier?

   What type of policy?

   Do you intend to discontinue this policy? ☐ Yes ☐ No

2. **Do you live in an institution?** ☐ Yes ☐ No
   If yes, name of institution Phone number

   Address

3. **Are you currently receiving Medicaid?** ☐ Yes ☐ No
   If yes, Medicaid number

Retiree's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name (as it appears on Medicare card)

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

Spouse or SRDP's Medicare number

Is this person entitled to Medicare Part A or Part B?

Part A (hospital) Yes Effective date No

Part B (medical) Yes Effective date No

Spouse or SRDP medical information

Your answers to question 3 below will not affect your eligibility to enroll in a Medicare Advantage plan.

1. **Do you have any health insurance other than Medicare?** Yes No
   If yes, through which carrier?

   What type of policy?

   Do you intend to discontinue this policy? Yes No
2. **Do you live in an institution?** Yes No
   If yes, name of institution

   Phone number

   Address
3. **Are you currently receiving Medicaid?** Yes No
   If yes, Medicaid number

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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Retiree's last name

Social Security number

3 Plan choice

Kaiser Foundation Health Plan of the Northwest

- [ ] Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington

- [ ] Kaiser Permanente WA Medicare Advantage

UnitedHealthcare

- [ ] UnitedHealthcare PEBB Balance
- [ ] UnitedHealthcare PEBB Complete

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.

Name of retiree's contracting primary care provider (refer to plan's provider directory)

Current patient? [ ] Yes [ ] No

Name of spouse's or SRDP's contracting primary care provider (refer to plan's provider directory)

Current patient? [ ] Yes [ ] No

2022 PEBB Program medical contractors

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

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
1-877-221-8221 (TTY: 711)

Kaiser Foundation Health Plan of Washington
1300 SW 27th Street
Renton, WA 98057
1-866-648-1928
TTY: 1-800-833-6388

UnitedHealthcare
PO Box 30770
Salt Lake City, UT 84130-0770
1-855-873-3268 (TRS: 711)

HCA is committed to providing equal access to our services. If you need an accommodation, please call us 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**.

Retiree's last name

Social Security number

4 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 law, 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 qualified. To the extent permitted by law, the PEBB Program may terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. I understand that it is a crime to knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of PEBB benefits.

I have read and understand this form, including the Statement of Understanding (on the next page). I know that I must refer to my plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage contract. I understand that if I sign this form after the date I wish my Medicare Advantage coverage to begin, I may be prevented from enrolling in the Medicare Advantage plan I selected until either the next open enrollment period or I qualify for a Special Enrollment Period. This could mean higher premiums and different coverage than would be provided under a Medicare Advantage plan.

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 rules and policies may result in my benefits selection being rejected or defaulted.

This form cannot be signed more than 90 days before the effective date of this coverage. (See Statement of Understanding on the next page for Medicare Advantage Plan coverage effective date.)

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where they reside) on this application means that I have read and understand the contents of the application.

Signature of retiree

Date

Signature of spouse or SRDP (if enrolling)

Date

Form return

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: 1-360-725-0771
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. **Note**: This is separate from PEBB My Account.

5 Authorized representative

If you are the authorized representative, read and sign below and provide the following information.
If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from the Medicare Advantage plan or by Medicare.

Signature of authorized representative

Date

Name

Relationship to retiree

Address

Phone

6 Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected in section 3 of this form, as long as this form is signed prior to the effective date, all medical services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage plan when required will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage plan will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including – but not limited to – physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision or coordination of benefits or to professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective the day PEBB insurance begins, or the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during the PEBB Program's annual open enrollment (November 1-30), then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date of enrollment. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so they may begin using the plan services as of the effective date of enrollment.

Please contact the plans listed below if you need information in another language or format.
Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and UnitedHealthcare are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.