HCA | Health Care Authority
Public Employees Benefits Board

2026 PEBB Retiree Open Enrollment Election/Change Form (form A-OE)

Instructions – Read before completing form

Forms must be received by the PEBB Program during the open enrollment period, October 27 – November 24, 2025. Approved changes are effective January 1, 2026.

Complete this form to make changes during the PEBB Program's annual open enrollment. This form replaces all retiree enrollment/change forms previously submitted. If you are newly eligible for PEBB retiree insurance coverage, use the PEBB *Retiree Election Form* (form A). All forms and documents are available on HCA's website at **hca.wa.gov/pebb-retirees**.

We use the term "non-Medicare" throughout this form. This means you are not enrolled in Medicare Part A and Part B.

Type or print in dark ink using all capital lettering in the spaces provided. Inaccurate, incomplete, or illegible information may delay coverage. Follow example to fill in form: *J O H N*

1 Subscriber

If you are enrolled in Medicare, this information needs to match Medicare record to avoid delays to coverage starting.

Social Security number

Date of dob (mm/dd/yyyy)

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

Permanent street address (PO box is not allowed)

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 This field is not required for enrollment. Your response is optional and will be kept private to the extent allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit **hca.wa.gov/gender-x**.

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 your Medicare card

Part B (medical) Yes No

If **Yes**, enter effective date from your Medicare card

Medicare number

If Yes, proof is required. Attach a copy of your entire Medicare benefit verification letter or a copy of your Medicare card to this form if we don't already have a copy. **You will not be enrolled until your proof of Medicare is received**. If you are eligible for Medicare, you must enroll and stay enrolled in both Part A and Part B.

⚠ Premium surcharges do not apply to subscribers who are 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. Refer to the *Retiree Enrollment Guide* or visit HCA's website at **hca.wa.gov/pebb-retirees** for more information.

If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. If this is a change to a previous attestation, submit the *PEBB Premium Surcharge Attestation Change Form*.

Does the tobacco use premium surcharge apply to you?

Check one:

No, 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. 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.

Subscriber's last name

Social Security number

Additions or changes

What change are you requesting? (Check all that apply.)

- Name change
- Address change
- Medical plan change
- Dental plan change
- Vision plan change (non-Medicare members only)

Add or remove family coverage

- Add a spouse, a state-registered domestic partner, or dependents.
- Remove a spouse, a state-registered domestic partner or dependents.

To terminate or defer coverage

- Terminate PEBB Retiree insurance coverage. I understand I cannot reenroll unless I regain eligibility. I understand I most also submit a *PEBB Medicare Plan Disenrollment Form* (form D) if I am or an enrolled dependent is in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP)
- Terminate dental and/or vision coverage.
- Defer (postpone) enrollment. Select the reason for deferral below. See the *PEBB Retiree Enrollment Guide* for reqiurements to defer and enroll after deferring.

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

Enroll after deferring

- Enroll after deferring. If you deferred enrollment, you must provide proof of your continuous enrollment in qualifying coverage since you defered. If you deferred while enrolled in Medicare and permanently living outside of the United States, and returned to live in the U.S., you must provide proof of enrollment in Medicare Part A and Part B; proof of continuous enrollment in a qualified coverage is waived while living outside of the U.S.

If deferring or enrolling after deferring. Check the box(es) below that apply to you.

- Enrolled as a dependent in a health plan sponsored by the PEBB Program or the School Employees Benefits Board (SEBB) Program. (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 qualified health plan coverage through a health benefits 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.
- **Medicare subscribers only:** Retirees and survivors enrolled in Medicare may defer enrollment if they permanently live outside of the United States.

Subscriber's last name | Social Security number

2 Spouse or state-registered domestic partner (SRDP)

If enrolling or removing a spouse or SRDP, complete this section. If not, then skip to the next section.

List your spouse or SRDP you wish to cover or remove from coverage. SRDP is defined in WAC 182-12-109. State-registered domestic partners include partners of legal unions from another jurisdiction, and that is substantially equivalent to a domestic partnership in Washington State. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law.

You must provide proof of their eligibility within the PEBB Program's enrollment timelines or they will not be enrolled. Timelines and a list of accepted documents are available on HCA's website at **hca.wa.gov/pebb-retirees**.

Your spouse or SRDP cannot be enrolled in two PEBB medical, dental, or vision accounts at the same time.

If your spouse or SRDP is enrolled in Medicare, this information needs to match their Medicare records to avoid delay to coverage starting.

If enrolling an SRDP, attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

Relationship to subscriber

☐ Spouse: Date of marriage:

☐ SRDP (Washington State): Partnership start date:

☐ SRDP (legal union): Start date:

Social Security number | Date of dob (mm/dd/yyyy) | Sex assigned at birth[1] ☐ Male ☐ Female

Last name | Gender identity[2] ☐ Male ☐ Female ☐ X

First name | Middle initial | Suffix

Permanent street address (if different from subscriber; PO Box is not allowed)

Address line 2

City | State

ZIP/Postal code | County

Coverage for spouse or SRDP

☐ **Cover** Effective date: January 1, 2026

☐ **Remove** Effective date: December 31, 2025

If removing a spouse due to divorce, attach a copy of the finalized divorce decree. If removing an SRDP due to dissolution, include a copy of the dissolution of state-registered domestic partnership. You must also submit *Form D* if your spouse or SRDP is enrolled in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP).

1 This field is required for health care services.

2 This field is not required for enrollment. Your response is optional and will be kept private to the extent allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit **hca.wa.gov/gender-x**.

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, effective date from Medicare card

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

Medicare number

If Yes, proof is required. Attach a copy of their entire Medicare benefit verification letter or a copy of their Medicare card to this form if we don't already have a copy. Write the subscriber's full name and the last four digits of their Social Security number on the copy. **Your spouse or SRDP will not be enrolled until their proof of Medicare is received.** If your spouse or SRDP is eligible for Medicare, they must enroll and stay enrolled in both Part A and Part B.

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

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium. See page 2 for instructions on how to respond..

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

No, the subscriber is 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 they have enrolled in or accessed one of the tobacco cessation resources.

Subscriber's last name | Social Security number

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

Response required if you are enrolling your spouse or SRDP. The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling a spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.

Answer these questions about your spouse or SRDP in 2026:

1. Are you covering your spouse or SRDP in a PEBB medical plan under your account?
   Yes No
2. Will they be eligible for medical coverage through their employer? (If they will not be employed, answer No.)
   Yes No
3. Will their employer offer at least one medical plan that serves their county of residence?
   Yes No
4. Have they chosen not to enroll in their employer's medical coverage?
   Yes No
5. Will the coverage offered by their employer not be through the PEBB Program or SEBB Program or a TRICARE plan? Answer **Yes** if their employer does not offer PEBB or SEBB coverage or a TRICARE plan. Answer **No** if their employer offers PEBB or SEBB coverage or a TRICARE plan.
   Yes No
6. Will their share of the medical premium through their employer be less than $137.76 per month?
   Yes No

If you answered **No** to any of these questions, check No below. You will not be charged the surcharge. If you answered **Yes** to all of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:
   a. Serve their county of residence.
   b. Have a monthly premium of less than $137.76 per month for the employee.
2. Use the SBC information to answer the questions in the *PEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response in the next section.

⚠ If you check **Yes** below or do not check any boxes below, you will be charged the $50 monthly premium surcharge.

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

- **No**, the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- **Yes**, I am subject to the $50 premium surcharge. I completed the *PEBB Spousal Plan Calculator*.
- **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator*.
- I need the PEBB Program to determine if the premium surcharge applies. I am submitting a printed *PEBB Spousal Plan Calculator*.

The *PEBB Spousal Plan Calculator* is available at **hca.wa.gov/pebb-retirees** under *Surcharges*.

Subscriber's last name | Social Security number

3 Dependents

If enrolling or removing a dependent, complete this section. If not, then skip to the next section.

List dependents you wish to enroll or remove from coverage. They 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. If enrolling more dependents, copy this section.

You must provide proof of their eligibility within the PEBB Program's enrollment timelines or they will not be enrolled. Timelines and a list of accepted documents are available on HCA's website at **hca.wa.gov/pebb-retirees**.

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

If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

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

If enrolling a child with a disability age 26 or older, submit a *PEBB Certification of a Child with a Disability*.

Relationship to subscriber

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

Social Security number | Date of birth (mm/dd/yyyy) | 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; PO Box is not allowed)

Address line 2

City | State

ZIP/Postal code | County

Coverage for dependent

- ☐ **Cover** Effective date: January 1, 2026
- ☐ **Remove from coverage** Effective date: December 31, 2025

1 This field is required for health care services.

2 This field is not required for enrollment. Your response is optional and will be kept private to the extent allowable by law. Gender X means a gender that is not exclusively male nor female. To learn more, visit **hca.wa.gov/gender-x**.

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:

Medicare number

If Yes, proof is required. Attach a copy of their entire Medicare benefit verification letter or a copy of their Medicare card to this form if we don't already have a copy. Write the subscriber's full name and the last four digits of their Social Security number on the copy. **Your dependent will not be enrolled until their proof of Medicare is received.** If your dependent is eligible for Medicare, they must enroll and stay enrolled in Medicare Part A and Part B.

⚠ Premium surcharges do not apply to subscribers who are 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 in addition to your monthly medical premium. See page 2 of this form for instructions on how to respond.

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

☐ **No**, the subscriber is 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.

☐ **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.

4 Medical plan selection

Contact the plans with questions about benefits and providers. Contact information is at the end of this form. If you or an enrolled dependent are in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP), and are moving to another type of medical plan, also submit a *PEBB Medicare Plan Disenrollment Form* (form D). **Note:** If you choose a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP), complete Section 11 of this form.

These plans have specific service areas. If you move out of the service area and your current medical plan is no longer available, you must select a new plan. If you do not, the PEBB Program will enroll you in a plan. You must report your new address to the PEBB Program and request a plan change **no later than 60 days** after you move.

If you permanently live in a location outside of the United States, PEBB medical plan enrollment will terminate on the last day of the month as required by federal law. You may defer enrollment in PEBB retiree insurance coverage as described in WAC 182-12-205 (3)(f).

Kaiser Foundation Health Plan of the Northwest [1] (Kaiser Permanente NW)

- ☐ Kaiser Permanente NW Classic
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[4]
- ☐ Kaiser Permanente NW Senior Advantage with Part D[2]

Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)

- ☐ Kaiser Permanente WA Classic[5]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[4]
- ☐ Kaiser Permanente WA Medicare Advantage with Part D[2, 3]
- ☐ Kaiser Permanente WA SoundChoice[5]
- ☐ Kaiser Permanente WA Value[5]

Premera Blue Cross

- ☐ Medicare Supplement Plan G[6]

Uniform Medical Plan (UMP), administered by Regence BlueShield and ArrayRx

- ☐ UMP Classic[4]
- ☐ UMP Classic Medicare with Part D (PDP)[7]
- ☐ UMP Select[4]
- ☐ UMP Consumer-Directed Health Plan[4]

UnitedHealthcare Medicare Advantage Prescription Drug

- ☐ UnitedHealthcare PEBB Balance[7] (MAPD)
- ☐ UnitedHealthcare PEBB Complete[7] (MAPD)

1. 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.
2. This Medicare plan is available only in certain counties. See "Medical plans available by county" at **hca.wa.gov/pebb-retirees**.
3. If someone on your account is not enrolled in Medicare, you must select Kaiser Permanente WA Classic, SoundChoice, or Value plan for them.
4. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.
5. Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA Medicare Advantage with Part D .
6. Also submit Form B to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.
7. These plans are only available to Medicare members who permanently live in the United States. Enrollment in these plans may not be retroactive. If the required forms are received after the date PEBB retiree insurance coverage is to begin, you and your enrolled dependents will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare or UMP Classic Medicare with Part D (PDP) coverage begins. Any non-Medicare members on your account will continue to be enrolled in UMP Classic.

5 Dental plan selection

You must enroll in medical coverage to enroll in dental. If you enroll in dental coverage, your dependents (if any) will also be enrolled in the same dental plan. Before you enroll, call the dental plan to make sure your provider accepts the specific plan and plan group you choose. Their contact information is at the end of this form.

- I wish to stay enrolled in my current dental plan.
- I wish to terminate dental. I understand that if I terminate dental for myself, dental is terminated for my enrolled dependents.
- I wish to enroll in or change my dental plan to (select a plan below):

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. Your out-of-pocket costs will be lower if you use a preferred provider.

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.
- **Willamette Dental of Washington (Group WA82)**, administered by Willamette Dental of Washington, Inc. You will select and receive services from a provider in the Willamette Dental network.

6 Vision plan selection

Available to non-Medicare members only. Choose one vision plan.
You must enroll in medical coverage to enroll in vision. Before you enroll, make sure the provider you want to use accepts the specific plan you choose. For Medicare members, vision is included in your medical plan, excluding Premera Plan G. A vision plan must be selected for all non-Medicare members (subscribers or dependents) who want vision benefits; all non-Medicare members will be enrolled in the same vision plan.

- I wish to stay enrolled in my current vision plan.
- I wish to terminate vision. I understand that if I terminate vision for myself, vision is terminated for all non-Medicare members.
- I wish to enroll in or change my vision plan to (select a plan below):
  - **Davis Vision by MetLife**, underwritten by Metropolitan Life Insurance Company ("MetLife")
  - **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
  - **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

⚠ **Plan contact information is at the end of this form.**

7 Payment

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:

☐ **Electronic debit service (EDS):** I will pay my monthly medical, dental (if elected), and vision (if elected) premiums and applicable premium surcharges by EDS. I will submit the *PEBB Electronic Debit Service (EDS) Agreement*. 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 to deduct medical, dental (if elected), and vision (if elected) premiums, and applicable premium surcharges I am required to pay from my retirement pension. I understand 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.

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

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 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.

If the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) determines that you owe a Medicare Part D late enrollment penalty, you will be billed separately by the plan. You are required to pay the Part D late enrollment penalty separately to the plan.

8 Subscriber agreement

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 plans 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 insurance 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 the applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly medical premiums (if I am not enrolled in Medicare Part A and Part B).

I understand I am responsible for paying any Medicare Part D late enrollment penalty associated with the Medicare Advantage with Part D plan or Uniform Medical Plan Classic Medicare with Part D (PDP) to the plan.

I understand if I enroll in PEBB retiree dental or vision, it is my responsibility to call the plan (not my provider) to verify my provider is covered by the dental plan network and vision plan network I selected.

I understand if I am or any enrolled dependent is eligible for Medicare Part A and Part B, we must enroll and stay enrolled in Part A and Part B.

If I choose to defer medical, dental, and vision for myself, in most cases, I cannot enroll my eligible dependents. 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 as long as I maintain and provide proof of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, as well as between each enrollment in qualifying coverages during the deferral period. A retiree or survivor enrolled in Medicare who defers enrollment while living outside of the United States and who returns to permanently live in the United States will have the opportunity to enroll in a PEBB health plan by submitting the required form and proof of enrollment in Medicare Part A and Part B within the HCA required enrollment timeframe. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or after the date of my permanent move back to the United States or the date I provide notification of such move, whichever is later, or no later than the last day of the PEBB Program's annual open enrollment.

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 may enroll or defer enrollment in PEBB retiree insurance coverage. The surviving dependent may need to complete the *PEBB Retiree Election Form* (form A). The PEBB Program must receive the form no later than 60 days after my death.

If I enroll in a Kaiser Medicare Advantage with Part D (MAPD), UnitedHealthcare Medicare Advantage with Part D (MAPD) plan, or UMP Classic Medicare with Part D (PDP), I certify that I have read and understand the Statement of Understanding at the end of this form. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage with Part D contract. I understand that enrollment in a MAPD or UMP Classic Medicare with Part D (PDP) plan may not be retroactive. If I enroll in a Kaiser Permanente MAPD plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser Permanente plan during the gap month(s) prior to when Kaiser Permanente MAPD coverage begins. If I elect to enroll in a UnitedHealthcare MAPD or UMP Classic Medicare with Part D (PDP) plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic coverage during the gap month(s) prior to when the UnitedHealthcare MAPD plan or UMP Classic Medicare with Part D (PDP) plan begins.

This form cannot be signed more than 90 days before the effective date of this coverage. (See Statement of Understanding in Section 11 for coverage effective date.)

This form replaces all election 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 last name

Social Security number

9 Signature

Please sign, date, and keep a copy for your records.

Subscriber signature

Date

Spouse or SRDP signature (only if enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D [PPD])

Date

Dependent signature (only if enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D [PDP])

Date

10 Form return

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

Secure message: Send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format or language, call 1-800-200-1004 (TRS: 711) or visit **hca.wa.gov/about-hca/language-access**.

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**.

11 Medicare Advantage and UMP Classic Medicare with Part D (PDP) agreement

We offer four Medicare Advantage with Part D (MAPD) plans: Kaiser Permanente of the Northwest Senior Advantage with Part D, Kaiser Permanente of Washington Medicare Advantage Plan with Part D, UnitedHealthcare PEBB Balance, and UnitedHealthcare PEBB Complete. We also offer UMP Classic Medicare with Part D (PDP). **If you are not enrolling in one of these plans, skip this section.**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) plan I have selected, 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 with Part D plan or UMP Classic Medicare with Part D (PDP) 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 with Part D plan or UMP Classic Medicare with Part D (PDP) will release my information to Medicare, and Medicare may release it for

(continued on next page)

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 with Part D plan or UMP Classic Medicare with Part D (PDP) at any time. By enrolling in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) 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 with Part D plan or UMP Classic Medicare with Part D (PDP), I authorize CMS to provide information to the plan I selected 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 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 with Part D plan or UMP Classic Medicare with Part D (PDP) 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 with Part D plan or UMP Classic Medicare with Part D (PDP) by sending a written request to the PEBB Program with Form D. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage with Part D or UMP Classic Medicare with Part D (PDP) plan providers.

I understand that as a member of the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected is effective the day PEBB insurance coverage 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, then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the PEBB Program will send me written notice of my effective date of enrollment. I understand that when my coverage begins I must get all of my medical (and prescription drug, if applicable) benefits from the plan. 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 with Part D plan or UMP Classic Medicare with Part D (PDP) identification card. Until you receive your plan 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 with Part D organization or UMP Classic Medicare with Part D (PDP) 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 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 with Part D plans; these plans and UMP Classic Medicare with Part D (PDP) are Employer Group Waiver Plans, all of which have contracts with the federal government. Enrollment depends on contract renewal.

Subscriber's last name

Social Security number

Medicare enrollment supplemental demographic information

Providing this demographic information is **optional** and will not affect your enrollment.

Preferred language other than English

- Spanish
- Other (please indicate)
- No selected preference

Preferred accessible format

- Braille
- Large print
- Audio CD
- Data CD
- No selected preference

Subscriber

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Spouse or SRDP

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Dependent

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

PEBB Program contractors

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

Medical

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2023
1-800-813-2000 (TRS: 711)
Medicare members: 1-877-221-8221 (TRS: 711)

Kaiser Foundation Health Plan of Washington
2715 Naches Ave SW
Renton, WA 98057
1-888-901-4636, TTY: 1-800-833-6388
Medicare members: 1-888-901-4600

Premera Blue Cross
PO Box 327
MS 295
Seattle, WA 98111
1-800-817-3049
TTY: 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield (for medical benefits)
PO Box 1106
Lewiston, ID 83501-1106
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by ArrayRx (for prescription drug benefits)
Non-Medicare members
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

UMP Classic Medicare with Part D (PDP): (ArrayRx for prescription drug benefits)
PO Box 40327
Portland, OR 97240-0327
1-833-599-8539 (TRS: 711)

UnitedHealthcare
Customer Service Department
185 Asylum Ave
Hartford, CT 06103
1-855-873-3268

Dental

DeltaCare, administered by Delta Dental of Washington
400 Fairview N, Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

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

Willamette Dental of Washington, Inc.
910 NE 82nd St.
Vancouver, WA 98665
1-855-433-6825 (TRS: 711)

Life insurance

Metropolitan Life Insurance Company (MetLife)
MetLife Recordkeeping Center
PO Box 14406
Lexington, KY 40512
(Plan #164995-1-G)
1-866-548-7139

Vision

Davis Vision by MetLife, underwritten by Metropolitan Life Insurance Company
Vision Care Processing Unit
200 Park Avenue
New York, NY 10166
1-888-496-4275
TTY: 1-800-523-2847

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company
4000 Luxottica Place
Mason, OH 45040
1-800-699-0993
TTY: 1-844-230-6498

Metropolitan Life Insurance Company (Vision Plan)
200 Park Avenue
New York, NY 10166
1-866-548-7139
TTY: 1-800-428-4833

Vision Service Plan (UMP Classic Medicare vision plan)
PO Box 997100
Sacramento, CA 95899-7100
1-844-299-3041 (TTY: 1-800-428-4833)