

## 2021 PEBB Retiree Election Form

**Complete this form to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage.** If you wish to make a change to an existing retiree account, please use the *2021 PEBB Retiree Change Form* (form E). All forms and documents mentioned, and a self-paced tutorial for form A, are available on HCA's website at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees).

Remember to read and sign Section 7. To enroll dependents, fill out Section 8 starting on page 11. This form replaces all retiree enrollment/change forms submitted in the past.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in dark ink and use all capital lettering in the spaces provided.

Example: J O H N

### Required

### Retiree, employee, or school employee information only

If you are a surviving spouse, state-registered domestic partner (defined in WAC 182-12-109), or dependent, provide the deceased employee or retiree's information below. Provide your personal information in Section 1.

Retiree, employee, or school employee last name

Social Security number

Retirement plan

Retirement date (or separation date for plan 3 or higher-education retirement plans)

#### Check one:

**Enrolling:** I am a new retiree or a surviving dependent requesting to enroll in coverage.

**Deferring:** I am a new retiree or a surviving dependent deferring (postponing) my coverage. You only need to complete Sections 1 and 7 of this form. See the *2021 PEBB Retiree Enrollment Guide* for details about deferring.

**Enrolling after deferring:** Date other qualifying medical coverage ended  
You must provide proof of your continuous enrollment in other qualifying coverages since your date of deferral with this form.

**Separating:** Eligible under Plan 3 or a higher-education retirement plan  
separating as of

### For new nonrepresented employees of a Washington State educational service district who are retiring:

Educational Service District (ESD)

When does your current health plan coverage through your ESD, COBRA, or continuation coverage end?

**Note:** If you are applying to enroll in retiree insurance coverage after your COBRA or continuation coverage ends, you must submit proof of your continuous health coverage with this form.

Social Security number	Date of birth	Sex assigned at birth <sup>1</sup>		
		Male	Female	
Last name		Gender identity <sup>2</sup>		
		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			

### 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:

<sup>1</sup> This field is required for health care services.

<sup>2</sup> 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](https://hca.wa.gov/gender-x).

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Subscriber's last name

Social Security number

### I wish to...

**Enroll:** (Check all that apply.)

Medical only

Medical and dental

Retiree term life insurance

**Defer:** Defer (postpone) my coverage. Except as stated below, this defers coverage for all eligible dependents.

Deferral date:

**Enroll after deferring coverage:** You will need to provide proof of continuous enrollment in one or more qualifying coverages (with start and end dates).

Date other qualifying coverage ended:

### If deferring or enrolling after deferring, check all the boxes below that apply to you.

Enrolled as a dependent in a health plan sponsored by the PEBB Program, a Washington State educational service district, 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 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.

 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 in medical coverage. 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 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](https://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](https://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. 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 *PEBB Premium Surcharge Attestation Help Sheet*.

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Social Security number

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### Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or state-registered domestic partner (SRDP), as defined by Washington Administrative Code 182-12-109, you wish to cover. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time. To enroll children, please complete Section 8 at the end of this form.

#### Relationship to subscriber

Spouse: date of marriage

**!** 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. A list of documents we will accept to verify their eligibility is available on HCA's website at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees).

SRDP: date registered

**!** All subscribers: If enrolling a SRDP, please attach proof of eligibility and a *2021 PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b).

Social Security number

Date of birth

Sex assigned at birth<sup>1</sup>

Male Female

Last name

Gender identity<sup>2</sup>

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

#### 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 eligible for 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 Premiera Blue Cross Medicare Supplement Plan G.

<sup>1</sup> This field is required for health care services.

<sup>2</sup> 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](https://hca.wa.gov/gender-x).

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Subscriber's last name

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### 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. **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](https://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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *2021 PEBB Premium Surcharge Attestation Help Sheet*.

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

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.

#### 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 *PEBB Spousal Plan Calculator* online.

**!** 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](https://hca.wa.gov/pebb-retirees) for instructions on how to respond.

**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*.

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### Medical plan selection

#### Kaiser Foundation Health Plan of the Northwest<sup>1</sup>

Kaiser Permanente NW Classic<sup>2</sup>

Kaiser Permanente NW Consumer-Directed Health Plan<sup>2,5</sup>

Kaiser Permanente NW Senior Advantage<sup>3</sup>

#### Kaiser Foundation Health Plan of Washington<sup>1</sup>

Kaiser Permanente WA Classic<sup>7</sup>

Kaiser Permanente WA Consumer-Directed Health Plan<sup>5</sup>

Kaiser Permanente WA Medicare Plan<sup>3,4</sup>

Kaiser Permanente WA SoundChoice<sup>6,7</sup>

Kaiser Permanente WA Value<sup>7</sup>

#### Premiera Blue Cross

Medicare Supplement Plan G<sup>8</sup>

#### Uniform Medical Plan (UMP), administered by Regence BlueShield

UMP Classic

UMP Select<sup>5</sup>

UMP Consumer-Directed Health Plan<sup>5</sup>

UMP Plus—Puget Sound High Value Network<sup>1,5</sup>

UMP Plus—UW Medicine Accountable Care Network<sup>1,5</sup>

#### UnitedHealthcare Medicare Advantage Prescription Drug<sup>9</sup>

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.)

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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](https://hca.wa.gov/pebb-retirees). Submit Form C with this form if you live in a county where a Medicare Advantage plan is available.

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

<sup>5</sup> These plans are available only if you and your enrolled dependents are not enrolled in Medicare.

<sup>6</sup> Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

<sup>7</sup> Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA’s Medicare Plan.

<sup>8</sup> 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.

<sup>9</sup> Also submit Form C to enroll in these plans. They are only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.

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### 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.

#### 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 verify your provider accepts the specific plan network and plan group.

**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. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

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### Retiree term life insurance

Retiree term life insurance is available only if you receive PEBB life insurance as an employee or SEBB life insurance as a school employee. You are not eligible for the retiree term life insurance plan if you qualify for a waiver of premium benefit under the PEBB employee life insurance or SEBB employee life insurance plans. To apply for retiree term life insurance, submit the *2021 PEBB MetLife Enrollment/Change Form for Retiree Plan* (including beneficiary designation) to the PEBB Program with this form.

I acknowledge that I have completed the PEBB MetLife Enrollment/Change form for Retiree Plan and will return it with this form.

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### Payment

You have three payment options: pension deduction, invoicing, and Electronic Debit Service. **In most cases, you must make your first payment by check before we can enroll you.**

#### How to make the first payment

If you select Electronic Debit Service (EDS) or invoicing below, you must make your first payment by check. Your first premium payment and applicable premium surcharges are due **no later than 45 days** after your 60-day election period ends. We will not enroll you in coverage until we receive your first payment. If you miss this deadline, you may lose your right to enroll in PEBB retiree insurance coverage. Make your check payable to Health Care Authority. Send it (and your EDS form, if you choose that option) to:

Washington State Health Care Authority  
PO Box 42691  
Olympia, WA 98504-2691

If you select pension deduction below, the PEBB Program will send you an invoice if payment is needed. Due to timing issues with the Department of Retirement Systems, a first payment may be required for premiums and applicable premium surcharges that were not deducted from your pension. If you receive an invoice, you must pay by check until your pension deduction is set up.

You cannot have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage or continuation coverage ended. 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.

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

**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 *2021 PEBB Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. I understand I must pay by check until I am notified of my EDS effective date, and that I must make my first payment before I will be enrolled. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. To pay by EDS for your retiree term life insurance, call MetLife at 1-866-548-7139.

**Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and applicable premium surcharges I am required to pay from my retirement pension. Deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.

**Invoicing:** I will pay my medical and dental premiums (if elected) 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. I understand that I must make my first payment before I will be enrolled.



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

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

I understand if I or any enrolled dependent are 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.

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 *2021 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 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 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](https://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](https://hca.wa.gov/pebb-retirees).

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Subscriber's last name

Social Security number

**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 98101-1374  
1-866-648-1928 (TTY: 1-800-833-6388)

#### **Premiera 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 N  
Suite 800  
Seattle, WA 98109-5371  
1-800-650-1583

#### **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.**

6950 NE Campus Way  
Hillsboro, OR 97124-5611  
1-855-433-6825 (TTY: 711)

### Life insurance contractor

#### **Metropolitan Life Insurance Company (MetLife)**

MetLife Recordkeeping Center  
PO Box 14406  
Lexington, KY 40512-4406  
(Plan #164995-1-G)  
1-866-548-7139

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### Dependents

List eligible dependents you wish to enroll. 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.

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

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](https://hca.wa.gov/pebb-retirees).

If enrolling a state-registered domestic partner's child or an extended dependent, also attach 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 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 on the form. Visit HCA's website at [hca.wa.gov/pebb-retirees](https://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

Social Security number

Date of birth

Sex assigned at birth<sup>1</sup>

Male

Female

Last name

Gender identity<sup>2</sup>

Male

Female

X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

<sup>1</sup> This field is required for health care services.

<sup>2</sup> 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](https://hca.wa.gov/gender-x).

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### 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 eligible for 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 Premiera Blue Cross Medicare Supplement Plan G.

### 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](https://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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *2021 PEBB Premium Surcharge Attestation Help Sheet*.

 Use additional forms to list more dependents.