2027 PEBB Retiree Election Form (form A)

Clear form

Submit this form to enroll in or defer (postpone) PEBB retiree insurance coverage. If you wish to make a change to an existing retiree account, use Benefits 24/7 at **benefits247.hca.wa.gov** or the *PEBB Retiree Change Form* (Form E). To review eligibility guidelines, see the "Retiree eligibility" section of the *PEBB Retiree Enrollment Guide*. All forms and documents mentioned 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. Inaccurate, incomplete, or illegible information may delay coverage. Download and save this form first. Do not complete it in a web browser.

⚠ Remember to read Section 10 and sign Section 11. This form replaces all retiree election or change forms submitted in the past.

1 Required: General information

Subscriber information only.

Provide the subscriber's information below to identify your account. Do not leave this section blank. Survivors, provide the deceased subscriber's information below and your personal information in Section 2.

Subscriber last name

Subscriber first name

Social Security number

Washington state-sponsored retirement plan

Retirement date (or separation date for Plan 2, 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. Select your reason for deferral below. See the *PEBB Retiree Enrollment Guide* for details about deferring.
- **Enrolling after deferring**: Select the reason for deferral below.
  If you deferred enrollment while enrolled in other qualifying medical coverage, provide the date the coverage ended (mm/dd/yyyy):

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

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

- Enrolled as a dependent in a medical 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 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.)

Subscriber's last name

Social Security number

☐ **Medicare subscribers only**: Enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage . (You may continue to cover eligible dependents who are not eligible for creditable coverage under Medicaid.)

☐ **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.)

☐ **Medicare subscribers only**: Effective January 1, 2025, retirees and survivors enrolled in Medicare may defer enrollment if they permanently reside outside of the United States.

☐ **Medicare subscribers only**: Effective January 1, 2026, retirees and survivors enrolled in Medicare may defer enrollment if they have a temporary absence from the United States that exceeds the permitted time allowed under the federal regulations and guidance of the Centers for Medicare and Medicaid Services (CMS).

2 Subscriber

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

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (PO Box not allowed)

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

Subscriber's last name

Social Security number

Are you enrolled in Medicare Part A or Part B?

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. **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.

Part A (hospital): ☐ Yes ☐ No

Part B (medical): ☐ Yes ☐ No

Medicare number:

⚠ 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 *PEBB 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.

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.

☐ **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.

☐ **Yes**, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.

Subscriber's last name

Social Security number

3 Spouse or state-registered domestic partner (SRDP)

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

List your spouse or SRDP you wish to cover. SRDP is defined in WAC 182-12-109 and includes partners of legal unions from another jurisdiction, and that is substantially equivalent to a domestic partnership in Washington. A state-registered domestic partner is treated the same as a legal spouse 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 record to avoid a delay in 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 birth (mm/dd/yyyy)

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber. PO Box not allowed)

Address line 2

City

State

ZIP/Postal code

County

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

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. Write the subscriber's full name and the last four digits of their Social Security number on the copy.

Part A (hospital): ☐ Yes ☐ No

Part B (medical): ☐ Yes ☐ No

Medicare number:

1 This field is required for health care services.

Subscriber's last name

Social Security number

⚠ 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 in medical coverage. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge in addition to your monthly medical premium. See page 3 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.

☐ **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.

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

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 a spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan Classic.

Answer these questions for your spouse or SRDP in 2027:

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 in 2027, 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 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 $140.61 per month?
   ☐ Yes ☐ No

If you answered **No** to any of these questions, check No on the next page. 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 $140.61 per month for the employee.
2. Use the SBC information to answer the questions in the *PEBB Spousal Plan Calculator* tool. You will get a Yes or No response from the calculator. Enter this response below. The *PEBB Spousal Plan Calculator* is available at **hca.wa.gov/pebb-retirees** under *Surcharges*.

Subscriber's last name

Social Security number

If you check **Yes** below or leave this section blank, you will be charged the monthly $50 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.
- **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator*.
- **Yes**, I am subject to the $50 premium surcharge. 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*.

Subscriber's last name

Social Security number

4 Dependents

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

List dependents you wish to enroll. 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.

Dependents cannot be enrolled in two PEBB medical, dental, or vision accounts at the same time. If your dependent is enrolled in Medicare, this information needs to match their Medicare records to avoid delays in coverage starting.

You must provide proof of your spouse's or SRDP's 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**.

Additional forms for dependents

If enrolling:

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

First name

Middle initial

Suffix

Street address (if different from subscriber's. PO Box not allowed)

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

Subscriber's last name

Social Security number

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

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 both Part A and Part B.

Part A (hospital): Yes No

Part B (medical): Yes No

Medicare number

Tobacco use premium surcharge

Response required if you are enrolling a dependent age 13 or older in medical coverage. If you check Yes or leave this section blank, you will be charged the $25 premium surcharge in addition to your monthly medical premium. See page 3 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.

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.

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

Subscriber's last name

Social Security number

5 Medical plan selection

Before you enroll, contact the plans to make sure the provider you want to use accepts the plan you choose. Contact information is at the end of this form.

These plans have specific service areas. Unless otherwise noted, most plans are available nationwide. 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, except as described in 2. below. See "Medical plans available by county" at **hca.wa.gov/pebb-retirees** for service areas.

1. If enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), we must receive your form before the date retiree coverage will begin or you will be enrolled in UMP Classic to avoid a coverage gap. Enrollment in your chosen plan will start on the first day of the month after we receive your form.
2. You must permanently reside in the U.S. and its territories if you intend to enroll in and remain enrolled in a PEBB Medicare plan. If you don't, enrollment in UMP Classic Medicare with Part D (PDP) or a Medicare Advantage with Part D plan will terminate on the last day of the month as required by federal law (WAC 182-08-196(5)).

Medicare plans

Available to members who are enrolled in both Medicare Part A and Part B. Unless otherwise noted, plans include Medicare Part D prescription drug coverage and vision coverage, and any non-Medicare members will be enrolled in UMP Classic.

Preferred Provider Organization (PPO)

Uniform Medical Plan (UMP)
Administered by Regence BlueShield and ArrayRx.

- ☐ **UMP Classic Medicare with Part D (PDP)**

Medicare Supplement Plan

Premera Blue Cross
Also submit *Form B* to enroll. Does not include vision or prescription drug coverage.

- ☐ **Medicare Supplement Plan G**

Medicare Advantage with Part D

Kaiser Foundation Health Plan of the Northwest
Available if you live in: Clark, Cowlitz, Skamania, parts of Wahkiakum (98612, 98647) County, or neighboring counties in Oregon. Any non-Medicare members will be enrolled in Kaiser Permanente NW Classic.

- ☐ **Kaiser Permanente NW Senior Advantage with Part D**

Kaiser Foundation Health Plan of Washington
Available in select counties and ZIP codes in Washington. Also select Kaiser Permanente WA Classic, SoundChoice or Value for any non-Medicare members.

- ☐ **Kaiser Permanente WA Medicare Advantage with Part D**

UnitedHealthcare

- ☐ **UnitedHealthcare PEBB Balance**
- ☐ **UnitedHealthcare PEBB Complete**

Non-Medicare plans

Available to members who are not enrolled in Medicare. All plans include prescription drug coverage. If any member is enrolled in Medicare Part A and Part B, first select the Medicare plan and if instructed, a non-Medicare plan in this section.

Kaiser Foundation Health Plan of the Northwest
Available in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.

- ☐ **Kaiser Permanente NW Classic**
- ☐ **Kaiser Permanente NW Consumer-Directed Health Plan**

Kaiser Foundation Health Plan of Washington
Available in select counties in Washington.

- ☐ **Kaiser Permanente WA Classic**
- ☐ **Kaiser Permanente WA Consumer-Directed Health Plan**
- ☐ **Kaiser Permanente WA SoundChoice**
- ☐ **Kaiser Permanente WA Value**

Uniform Medical Plan (UMP)

- ☐ **UMP Classic**
- ☐ **UMP Consumer-Directed Health Plan**
- ☐ **UMP Select**

Subscriber's last name | Social Security number

6 Dental plan selection

Choose one dental plan. You must enroll in medical coverage to enroll in dental. If you enroll in dental coverage, your dependents will also be enrolled in the same dental plan. Before you enroll, contact the 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.

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.
- **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.

Decline dental enrollment

- I decline dental enrollment

7 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, contact the plan to make sure the provider you want to use accepts the 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.

- **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")

Decline vision enrollment

- I decline vision enrollment

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

8 Retiree term life insurance

Retiree term life insurance is available only if you received 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 until that waiver of premium benefit ends. To apply for retiree term life insurance, submit the *MetLife Enrollment/Change Form for Retiree Plan* (including beneficiary designation) to the PEBB Program with this form.

- I want to enroll in retiree term life insurance and acknowledge that I have completed the *MetLife Enrollment/Change Form for Retiree Plan* and will return it with this form.
- I decline retiree term life insurance.

Subscriber's last name

Social Security number

9 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 your 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.** 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 the first payment is needed. Due to timing issues with the Department of Retirement Systems, your first payment may not be deducted from your pension. If you receive an invoice, you must pay by check.

You cannot have a gap in coverage. Premiums are due back to the first of the month in which your PEBB retiree insurance coverage became effective. 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) plan determines that you owe a Medicare Part D late enrollment penalty or an Income Related Monthly Adjustment Amount (IRMAA), you are required to pay these amounts separately to the plan as billed.

How would you like to pay?

- **Electronic debit service (EDS)**: I will pay my monthly elected plan 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**, 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 if elected plan premiums, retiree term life insurance (if elected), and applicable premium surcharges I am required to pay from my retirement pension. I understand that deductions are taken at the end of the month that I 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 elected plan premiums and applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance (if elected). **I understand that I must make my first payment before I will be enrolled**.

Subscriber's last name

Social Security number

10 Subscriber agreement

After reading this section, sign Section 11 before submitting the form.

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 or Income Related Monthly Adjustment Amount (IRMAA) 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 both 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. The PEBB Program must receive my enrollment form **no later than 60 days** after other qualifying medical coverage ends, or no later than the last day of the PEBB Program's annual open enrollment. A retiree or survivor enrolled in Medicare whose enrollment is deferred while permanently residing outside of the United States or who had a temporary absence from the United States that exceeded the permitted time allowed and who returns to the United States will have the opportunity to enroll in a PEBB health plan by submitting the required form, proof of enrollment in Medicare Part A and Part B, proof of permanent residence in the United States, and proof they currently reside in the United States within the HCA required enrollment timeframe. The PEBB Program must receive the enrollment form **no later than 60 days** after the date the permanent move begins, or 60 days following the month of the permanent move, whichever is later.

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 am electing to enroll in a Medicare Advantage with Part D (MAPD) plan or the UMP Classic Medicare with Part D (PDP) plan, I certify that I have read and understand the Statement of Understanding in Section 13. 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 elect to 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.

(Continued on next page)

Subscriber's last name

Social Security number

This form cannot be signed more than 90 days before the effective date of this coverage. (See Statement of Understanding in Section 13 for coverage effective date.)

This form replaces all election or change forms previously submitted to the PEBB Program. If I am 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.

11 Signature

Please sign, date, and keep a copy for your records.
I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this form means that I have read and understand the contents of this form. If signed by an authorized representative, this signature certifies that this person is authorized under state law to complete this enrollment, and documentation of this authority is available upon request by Medicare.

Subscriber/authorized representative signature

Date

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

Date

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

Date

12 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**.

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**.

Subscriber's last name

Social Security number

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

Read this section if you are enrolling in: Kaiser Permanente of the Northwest Senior Advantage with Part D, Kaiser Permanente of Washington Medicare Advantage Plan with Part D, UnitedHealthcare PEBB Balance, UnitedHealthcare PEBB Complete, or UMP Classic Medicare with Part D (PDP).

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 under 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 and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage or Part D plan.

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 Medicare Advantage plan or UMP Classic Medicare with Part D (PDP). 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 keep Medicare Hospital (Part A) and Medical (Part B) to stay in my selected plan. I also authorize the Medicare Advantage with Part D plan's or UMP Classic Medicare with Part D (PDP) 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 residing out of the service area or temporarily leaving the service area for more than the permitted time allowed under the federal regulations and guidance of CMS,, and that my plan must disenroll me and will return me to 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 plan 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

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. Benefits and services provided by my selected plan and contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my selected plan will pay for benefits or services that are not covered. 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 Medicare Advantage with Part D or UMP Classic Medicare with Part D (PDP) 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

(Continued on next page)

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 Alask a Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorr o
- 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 Alask a Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorr o
- 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 Alask a Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorr o
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Subscriber's last name

Social Security number

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
1-888-907-4636, TTY: 1-800-833-6388
Medicare members: 1-888-901-4600
(TRS: 711)

Premera Blue Cross
PO Box 327
MS 295
Seattle, WA 98111
1-800-722-1471
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
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

UMP Classic Medicare with Part D (PDP):
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

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

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

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

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
Fidelity Security Life (FSL)
3130 Broadway
Kansas City, MO 64111
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)

Life Insurance

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