Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Clear Form

A

2019 Retiree Coverage Election Form

Check one:

- ☐ **Enrolling:** I am a new retiree or a surviving dependent **applying** for coverage.
- ☐ **Deferring:** I am a new retiree or a surviving dependent **deferring** (postponing) my coverage. See pages 29-32 in *2019 Retiree Enrollment Guide* for details about deferring.
- ☐ **Enrolling after deferring:** Date other qualifying medical coverage ended _____.
- ☐ **Separating:** Eligible under Plan 3 retirement plan, **separating** as of _____.

Required **Retiree or employee information only**	Retiree or employee name		
	Social Security number	Retirement plan	Retirement date

For new Washington State school district, charter school, or educational service district (ESD) retirees only	School district
	When does your current medical/dental coverage through your school district, charter school, ESD, or COBRA end? _____ (mm/dd/yyyy). **Note:** If you are applying to enroll in retiree insurance coverage after your COBRA coverage ends, you must submit proof of your continuous health coverage with this form.

Section 1: Subscriber information *See attached instruction sheet for more information.*

Social Security number	Last name	First name	Middle initial	Sex M F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Home phone number ( )	Alternate phone number ( )

Subscriber enrollment

A. Enroll: ☐ Medical only ☐ Medical and dental ☐ Retiree term life insurance

B. 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 begin and end dates).
Date other coverage ended _____

If deferring or enrolling after deferring, check the box below that applies to you.

- ☐ Enrolled in a PEBB Program, Washington State school district, charter school, or educational service district-sponsored health plan as a dependent.
- ☐ Enrolled in employer-based group medical as an employee or employee's dependent, including COBRA coverage or continuation coverage. This does not include an employer's retiree coverage.
- ☐ Enrolled in medical coverage as a retiree or dependent in a TRICARE plan, CHAMPVA, 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 (Washington Apple Health) 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.
- ☐ **Non-Medicare retirees 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.

HCA is committed to providing equal access to our services.
If you need accommodation, please call 1-800-200-1004 or (TRS: 711).

(continued)

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number

Section 2: Spouse or state-registered domestic partner information

See attached instruction sheet for more information.

Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)

Street address Apt./unit number (if different from subscriber)	City	State	ZIP Code

A. Relationship to subscriber ☐ Spouse: date of marriage _____

☐ State-registered domestic partner: date registered _____

B. Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. For instructions, see the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees**. **If you check YES below or leave this section blank, you will be charged the monthly $50 monthly premium surcharge in addition to your monthly premium.**

Does the spouse or state-registered domestic partner coverage premium surcharge apply to you?

☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ **YES, I am subject to the $50 monthly premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and completed the 2019 Spousal Plan Calculator.

☐ **NO, I am not subject to the $50 monthly premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and if needed, completed the 2019 Spousal Plan Calculator online.

Which questions (if any) on the 2019 *Premium Surcharge 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

I am completing and submitting the 2019 Spousal Plan Calculator found at **www.hca.wa.gov/erb** for the PEBB Program to determine.

Section 3: Dependent information *See attached instruction sheet for more information.*

1	Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Relationship to subscriber	Date of birth (mm/dd/yyyy)	Child Stepchild (not legally adopted) Extended dependent (attach copy of court order)	Disabled (check only if age 26 or older)

Street address Apt./unit number	City	State	ZIP Code

2	Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Relationship to subscriber	Date of birth (mm/dd/yyyy)	☐ Child ☐ Stepchild (not legally adopted) ☐ Extended dependent (attach copy of court order)	☐ Disabled (check only if age 26 or older)

Street address Apt./unit number	City	State	ZIP Code

(continued)

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number

Section 4: Medicare enrollment *See attached instruction sheet for more information.*

Subscriber	Spouse/state-registered domestic partner	Dependent 1	Dependent 2
A. Enrolled in Medicare Part(s) A (hospital) and/or B (medical)?*			
Part A Yes No Effective date _____ Part B Yes No Effective date _____	Part A Yes No Effective date _____ Part B Yes No Effective date _____	Name: _____ Part A Yes No Effective date _____ Part B Yes No Effective date _____	Name: _____ Part A Yes No Effective date _____ Part B Yes No Effective date _____
B. Enrolled in Medicare Part D (prescription drug coverage)? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross.			
Part D Yes No Effective date _____	Part D Yes No Effective date _____	Part D Yes No Effective date _____	Part D Yes No Effective date _____
C. Enrolled in Medicaid with Medicare Part D?			
Yes No Effective date _____	Yes No Effective date _____	Yes No Effective date _____	Yes No Effective date _____
D. Receiving Social Security Disability?			
Yes No Effective date _____	Yes No Effective date _____	Yes No Effective date _____	Yes No Effective date _____

*If yes, proof is required. Attach a copy of your or your dependent's Medicare card (or all pages of the entitlement letter) to this form if we don't already have a copy. Write your full name and last four digits of your Social Security number on the copy.

Section 5: Tobacco use premium surcharge *See attached instruction sheet for more information.*

Only complete this section if you are not enrolled in Medicare Part A and Part B. The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B and you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. **If you check YES or leave this section blank** for you and any enrolled dependents, you will be charged the premium surcharge. See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

Subscriber	Spouse/state-registered domestic partner	Dependent 1	Dependent 2
☐ **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 the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.	☐ **YES,** I am subject to the $25 premium surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months. ☐ **NO,** I am not subject to the $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.	Name_____ ☐ **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 has enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.	Name_____ ☐ **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 has enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet*.

(continued)

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number

Section 6: Medical plan selection *See attached instruction sheet for more information.*

Kaiser Foundation Health Plan of the Northwest[6]

- ☐ Kaiser Permanente NW Classic[7]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[4,7]
- ☐ Kaiser Permanente NW Senior Advantage[1]

Kaiser Foundation Health Plan of Washington[6]

- ☐ Kaiser Permanente WA Classic[3]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[4]
- ☐ Kaiser Permanente WA Medicare Plan[1,2]
- ☐ Kaiser Permanente WA SoundChoice[3, 8]
- ☐ Kaiser Permanente WA Value[3]

☐ **Premera Blue Cross Medicare Supplement Plan F**[5]

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan[4]

UMP Plus (select a network)

- ☐ UMP Plus–Puget Sound High Value Network[4,6]
- ☐ UMP Plus–UW Medicine Accountable Care Network[4,6]

1. These Medicare Advantage plans are available in certain counties to Medicare enrollees. Also complete and attach Form C if you live in a county where Medicare Advantage is available.
2. If you cover dependents not enrolled in Medicare Part A and Part B, you may also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.
3. This plan is available only if at least one member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA's Medicare Plan.
4. These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate your dependent's PEBB coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.
5. Also complete and return Form B to enroll in Premera Blue Cross Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.
6. These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program **no later than 60 days** after you move.
7. Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.
8. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

Section 7: Dental plan selection *See attached instruction sheet for more information.*

You must enroll in medical coverage to enroll in dental. **If you enroll in dental, you must remain enrolled for at least two years.** Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans, not your dentist, for benefits information. The plans' contact information is located 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 will select and receive care from a primary care dental provider in the DeltaCare network. **Before you enroll, call DeltaCare at 1-800-650-1583** to verify your provider accepts the specific plan and plan group. ☐ **Willamette Dental of Washington, Inc.** (Group WA82) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan.

(continued)

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number

Section 8: Retiree Term Life Insurance election *See attached instruction sheet for more information.*

Retiree term life insurance is available only if you receive PEBB life insurance as an 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 plans.
To apply for retiree term life insurance, complete and return the MetLife *Enrollment/Change form for Retiree Plan* (including beneficiary designation) to the PEBB Program with this form.

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

Section 9: Payment authorization *See attached instruction sheet for more information.*

Your first premium payment and applicable premium surcharge are due to the Health Care Authority **no later than 45 days** after your 60-day election period ends. You must make the first payment before you will be enrolled.

How would you like to pay your medical, dental, and life insurance premiums (if elected) and any applicable premium surcharges?	How to make the first payment
❑ **Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and any 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.	If you select pension deduction, the PEBB Program will send you an invoice if payment is needed. Due to timing issues with DRS, 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.
❑ **Invoicing:** I will pay my medical and dental (if elected) premiums and any applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. ❑ **Electronic Debit Service (EDS):** I will complete and submit the *Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. I will pay my monthly premium(s) and any applicable premium surcharges by check until notified of my EDS effective date. 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, contact MetLife at 1-866-548-7139.	If you select one of the options at the left for your medical and dental premium with any applicable surcharges, make your check payable to **Health Care Authority.** Send it (with your EDS form, if elected) to: Washington State Health Care Authority PO Box 42691 Olympia, WA 98504-2691 Your first payment is due no later than 45 days after your 60-day election period ends.

Note: 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.

(continued)

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number

Section 10: Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My dependents and I may also lose PEBB benefits 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 knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime and can result in 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 any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly premium (if I am not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, I must remain enrolled in retiree dental for at least two years unless I defer 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 entitled to Medicare Part A and Part B, we must enroll and remain 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 (November 1-30) 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 rules. I understand in most cases, enrollment will be deferred effective the first of the month following the date this form is received by the PEBB Program unless a future date is provided.

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

This form replaces all *Retiree Election or Change Forms* previously submitted to the PEBB Program. If I am a retiree 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 rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, go to www.hca.wa.gov/erb.

Be sure to sign and date this form and keep a copy for your records.
Mail completed form and documentation to:
Washington State Health Care Authority, PEBB Program, PO Box 42684, Olympia, WA 98504-2684 **or fax to:** 360-725-0771
Questions? Visit our website at **www.hca.wa.gov/pebb-retirees** or call us at 1-800-200-1004.

Subscriber's signature _____Date _____

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

2019 PEBB Medical Contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101-1374
1-866-648-1928 or TTY 1-800-833-6388

Premera Blue Cross
P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

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

2019 PEBB Dental Contractors

DeltaCare,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800, Seattle, WA 98109-5371

Uniform Dental Plan,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800, Seattle, WA 98109-5371
1-800-537-3406

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

2019 PEBB Program 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

Retiree Coverage Election Form (Form A) instructions

All forms and documents mentioned here are available at w**ww.hca.wa.gov/pebb-retirees** under *Forms & publications.*

Note: If you are already enrolled in Public Employees Benefits Board (PEBB) coverage and need to make changes to your existing retiree account, **complete the *Retiree Coverage Change Form* (Form E)**.

Before you begin

Use these instructions to complete Form A. The form must be typed or printed clearly in dark ink. Do not return these instructions with Form A.

Timelines to enroll

If you are...	The PEBB Program must receive Form A...
A new retiree (or separating employee eligible under Plan 3 retirement) applying to enroll	**No later than 60 days** after your employer-paid coverage*, COBRA coverage, or continuation coverage ends*
A new retiree **deferring (postponing) enrollment** in a PEBB retiree health plan	**In most cases, no later than 60 days** after your employer-paid coverage*, COBRA, or continuation coverage ends*. You must maintain continuous enrollment in other qualifying coverage while you defer your enrollment. For more information and timelines about deferring, see the *Retiree Enrollment Guide* or visit **www.hca.wa.gov/pebb-retirees** and click on *Defer retiree coverage.*
An eligible elected or full-time appointed official of the legislative or executive branch of state government	**No later than 60 days** after you leave public office
A dependent becoming eligible as a survivor (not including emergency service personnel killed in the line of duty)	• For an eligible survivor of an employee who passes away, no later than 60 days after the later of the date of the employee's death or the date your PEBB, school district, educational service district, or charter school coverage ends. • For an eligible survivor of a retiree who passes away, no later than 60 days after the date of the retiree's death.
Enrolling after deferring coverage	No later than 60 days after the date your other qualifying coverage ends. Proof of continuous coverage in one or more qualifying coverages from the date of deferral will be required (with begin and end dates).

Additional forms or documents you may need to complete and submit with Form A

- If enrolling in Premera Blue Cross Medicare Supplement Plan F, you must also complete and submit the Group Medicare Supplement Enrollment Application **(Form B).**
- If enrolling in a Medicare Advantage plan, you must also complete and submit the *Medicare Advantage Plan Election Form* **(Form C).**
- If enrolling a state-registered domestic partner or the partner's child, you must also complete and submit the *Declaration of Tax Status form*.
- If enrolling a dependent with a disability age 26 or older, you must also complete and submit the *Certification of a Child with a Disability* form and return as instructed on the form.
- If enrolling an extended dependent, you must also complete and submit the *Extended Dependent Certification* form.
- If enrolling in life insurance, also complete and submit the *MetLife Enrollment/Change form for retiree Plan* form

Submit dependent verification documents if:

- You are enrolling a state-registered domestic partner and/or their dependents.
- You (the subscriber) are not enrolled in Medicare Part A and Part B and are enrolling a dependent.

A list of documents we will accept to verify your dependent's eligibility is available in the *Retiree Enrollment Guide* or at **www.hca.wa.gov/pebb-retirees.**

How to submit your completed enrollment form(s) and documentation

Mail to	Washington State Health Care Authority PEBB Program PO Box 42684 Olympia, WA 98504-2684	**Electronically submit:** Send a secure online message to PEBB Customer Service by registering for an account at **www.fuzeqna.com/pebb/consumer/question.asp.** **Note:** You must sign and date any forms you attach to a secure online message.
Fax to:	360-725-0771	

How to submit your first payment (required even if you chose electronic debit service)

Your first premium payment and any applicable premium surcharge(s) are due **no later than 45 days** after your 60-day election period ends. You must make the first payment before you will be enrolled.

Please make checks payable to Health Care Authority and send to:

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

(continued)

How to complete Form A

After you complete each section of the form that applies to you, check it off. Do not return the checklist below with your Form A.

☐ Required information section

- Print the name of the retiree, Social Security number (SSN), retirement plan (e.g. PERS, TRS, SERS, etc.), retirement date, and other appropriate information.
- If you are a surviving spouse, surviving state-registered domestic partner (defined in WAC 182-12-260(2)), or surviving dependent, provide the SSN of the deceased retiree or employee in the "Retiree or employee information only" section. Provide your SSN and information in Section 1: Subscriber Information.

☐ Section 1: Subscriber information

- Print your information in the subscriber section.
- Check your enrollment election choice. You can enroll or defer.
  - **A. Enroll.** If you are enrolling, check the appropriate box(es).
  - **B. Defer.** If you are deferring (postponing) coverage or enrolling after deferring, check the appropriate box and identify the deferral reason. The reasons listed are the **only** reasons you can defer enrollment in a PEBB retiree health plan.

☐ Section 2: Spouse or state-registered domestic partner information

Only complete this section if you want to cover an eligible spouse or state-registered domestic partner (as defined in WAC 182-12-260(2)).

Subscribers **not** enrolled in Medicare Part A and Part B must also:

A. Provide proof of your spouse/state-registered domestic partner's dependent eligibility within PEBB's enrollment timelines, **and**

B. Attest to the spouse or state-registered domestic partner coverage premium surcharge. The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. For help determining whether you need to attest, see the *2019 Premium Surcharge Help Sheet* in the *2019 Retiree Enrollment Guide*. You can also visit **www.hca.wa.gov/pebb-retirees** and click on *Surcharges* for more information.

Note: If adding a state-registered domestic partner, attach a completed *Declaration of Tax Status* form and proof of dependent eligibility within PEBB's enrollment timelines.

☐ Section 3: Dependent information

Only complete this section if you want to cover eligible dependents, including children as defined in WAC 182-12-260(3). Dependents cannot be enrolled on two PEBB medical or dental accounts at a time.

Non-Medicare subscribers: If you are enrolling dependents, you must also provide proof of their eligibility for each dependent within PEBB's enrollment timelines or they will not be enrolled.

- If enrolling a **state-registered domestic partner's child**, also complete and submit the *Declaration of Tax Status* form and proof of the dependent's eligibility.
- If enrolling a **dependent child with a disability** age 26 or older, also complete and submit the *Certification of a Child with a Disability* form and return as instructed on the form.
- If enrolling an **extended dependent**, also complete and submit the *Extended Dependent Certification* form.

☐ Section 4: Medicare enrollment information

Check the appropriate boxes to indicate the Medicare enrollment status for you and any enrolled dependents. Respond to the following questions:

A. Enrolled in Medicare Part(s) A and/or B? If yes, proof is required. If we don't already have a copy of your or your dependent's Medicare card, attach a copy of the enrollee's card or a copy of all pages of the entitlement letter to Form A. Write your full name and last four digits of your Social Security number on the copy.

B. Enrolled in Medicare Part D (prescription drug coverage)? If yes, you may only enroll in Premera Blue Cross Medicare Supplement Plan F.

C. Enrolled in Medicaid with Medicare Part D?

D. Receiving Social Security Disability?

☐ Section 5: Tobacco use premium surcharge

Only complete this section if you are not enrolled in Medicare Part A and Part B (non-Medicare). You only need to complete this section if you are changing an existing attestation or are enrolling new dependents. Responses are only required for dependents age 13 or older.

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you are **not** enrolled in Medicare Part A and Part B and you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. **If you check YES or leave this section blank** for you and any enrolled dependents, you will be charged the premium surcharge. See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

Section 6: Medical plan selection

Check the box for the medical plan you wish to enroll in Check the box for the medical plan you are eligible for and wish to enroll in. You may need to complete and submit additional forms, which are listed in the right column of Section 6.

Section 7: Dental plan selection

Only complete this section if you are enrolling in dental coverage. You must enroll in medical coverage to enroll in dental.

- If you select dental coverage for yourself, **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).
- Before you select a dental plan, call the plan (not your dentist) to make sure your provider participates with the plan.

Section 8: Retiree Term Life election

Only complete this section if you are eligible for and electing to enroll in Retiree Term Life Insurance. You must also submit the MetLife enrollment/change form for Retiree Plan with Form A. If you do not submit the MetLife form, you may miss your opportunity to enroll. If we determine that you are not eligible for retiree term life insurance, you will receive a denial letter with your appeal rights.

Section 9: Payment authorization

Choose the method for your first payment (and any applicable premium surcharges). Read this section carefully, as your first payment may be required to begin coverage. Your first premium payment and applicable premium surcharge are due to the Health Care Authority no later than 45 days after your 60-day election period ends. If you choose Electronic Debit Service (EDS), also complete and submit the *Electronic Debit Service Agreement* form.

You must make the first payment before you will be enrolled. Mail your payment and the EDS form, if elected, to the address listed in this section.

Section 10: Signature

Read Section 10 carefully to understand your responsibilities for Form A. Then sign and date this section to complete your enrollment form. **Mail Form A and any other required forms** to the address listed in this section.