Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Temporary change to the retiree enrollment deadline

Some information in this document has changed because of the Health Care Authority's response to the COVID-19 state of emergency. The Governor announced the state of emergency on February 29, 2020.

On April 2, 2020, the PEB Board passed a resolution to **extend the retiree enrollment deadline to 30 days past the date the Governor ends the state of emergency**.

- This means you may have extra time to enroll in PEBB retiree insurance coverage. For example, if your last day to enroll in PEBB retiree insurance coverage is April 30, and the state of emergency ends May 15, then your enrollment period will be extended to June 15.
- If your last day to enroll occurs more than 30 days after the last day of the state of emergency, your deadline **will not** be extended. For example, if your last day to enroll is July 31, and the state of emergency ends May 15, the extended enrollment date will be June 15. Your enrollment deadline will not be extended.
- The last day of the state of emergency is unknown at this time. We will communicate more information to you as it becomes available at **hca.wa.gov/coronavirus.**

Your first payment is due 45 days after the last day of your enrollment period, whether or not your enrollment period is extended.

Learn more about these and other resolutions at **hca.wa.gov/coronavirus**.

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Clear form A

2020 PEBB Retiree Coverage Election Form

Complete this form to apply to enroll in or defer (postpone) enrollment in retiree insurance coverage. If you wish to make a change to an existing retiree account, please use the *2020 PEBB Retiree Coverage Change Form* (form E).

Remember to read and sign page 9. To enroll dependents, fill out Section 8 starting on page 10. This form replaces all retiree enrollment/change forms submitted in the past.

Type or print clearly in dark ink, use only capital block lettering inside the boxes as shown in the example. Inaccurate, incomplete, or illegible information may delay coverage.
Follow example to fill in form:

J O H N

Required **Retiree or employee information only**

Retiree or employee last name

Social Security number – –

Retirement plan

Retirement date / /

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. Also complete Section 1 and Section 7 of this form. See the *2020 PEBB 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 / /

For new nonrepresented employees of a Washington State educational service district (ESD) who are retiring:

Educational service district

When does your current medical/dental 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.

Subscriber's last name

Subscriber's Social Security number

Section 1 Subscriber information and enrollment

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex

M F

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP Code

County of residence

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP Code

Premium surcharges only apply to subscribers who are not 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. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

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 *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Subscriber's Social Security number

Section 1 Subscriber information and enrollment *(continued)*

☐ **Enroll:**

☐ Medical only ☐ Medical and dental ☐ Retiree term life insurance

☐ **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 the box(es) below that applies to you.

☐ Enrolled in a PEBB Program, a Washington State educational service district, or a School Employees Benefits Board (SEBB) Program sponsored health plan as a dependent. This includes coverage under COBRA or continuation coverage.

☐ Enrolled in employer-based group medical as an employee or 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 retirees:** Enrolled in qualified health plan coverage through a health benefit exchange, not including Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

Are you enrolled in Part(s) A and/or B of Medicare? 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. Write your full name and the last four digits of your Social Security number on the copy. If you are entitled to Medicare, you must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Part A (hospital) ☐ Yes ☐ No If yes, effective date / /

Part B (medical) ☐ Yes ☐ No If yes, effective date / /

Are you enrolled in Medicare Part D (prescription drug coverage)? If **Yes**, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

☐ Yes ☐ No If yes, effective date / /

Are you enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No If yes, effective date / /

Do you receive Social Security Disability?

☐ Yes ☐ No If yes, effective date / /

Subscriber's last name

Subscriber's Social Security number

Section 2 Spouse or state-registered domestic partner information

List an eligible spouse or state-registered domestic partner, 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.

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. **All subscribers:** If enrolling a state-registered domestic partner, please attach proof of eligibility and a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b). A list of documents we will accept to verify the dependent's eligibility is available at **hca.wa.gov/pebb-retirees**.

Relationship to subscriber

☐ Spouse: date of marriage / /

☐ State-registered domestic partner: date registered / /

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy) / /

Social Security number – –

Sex ☐ M ☐ F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code –

Is this person enrolled in Part(s) A and/or B of Medicare? 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. Write your full name and the last four digits of your Social Security number on the copy. If they are entitled to Medicare, they must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Part A (hospital) ☐ Yes ☐ No

If yes, effective date / /

Part B (medical) ☐ Yes ☐ No

If yes, effective date / /

Is this person enrolled in Medicare Part D (prescription drug coverage)? If **Yes**, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

☐ Yes ☐ No

If yes, effective date / /

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No

If yes, effective date / /

Does this person receive Social Security Disability?

☐ Yes ☐ No

If yes, effective date / /

2020 PEBB Retiree Coverage Election Form

Subscriber's last name

Subscriber's Social Security number

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Premium surcharges only apply to subscribers who are not 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. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

☐ **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 *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to PEBB's Uniform Medical Plan Classic. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**. If you check **Yes** below or leave this section blank, you will be charged the $50 premium surcharge.

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

☐ **Yes, I am subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 PEBB Spousal Plan Calculator* at **hca.wa.gov/pebb-retirees**.

☐ **No, I am not subject to the $50 premium surcharge.**
I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *2020 PEBB Spousal Plan Calculator*. If **No**, which questions on the *2020 PEBB Premium Surcharge Attestation Help Sheet* did you check **No** (if any)? 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 *2020 PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *2020 PEBB Spousal Plan Calculator*.

Subscriber's last name

Subscriber's Social Security number

Section 3 Medical plan selection *See instruction sheet for more information.*

Kaiser Foundation Health Plan of the Northwest[1]

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2, 5]
- ☐ Kaiser Permanente NW Senior Advantage[3]

Kaiser Foundation Health Plan of Washington[1]

- ☐ Kaiser Permanente WA Classic[7]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA Medicare Plan[3, 4]
- ☐ Kaiser Permanente WA SoundChoice[6, 7]
- ☐ Kaiser Permanente WA Value[7]

Premera Blue Cross

- ☐ Premera Blue Cross Medicare Supplement Plan G[8]

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus—Puget Sound High Value Network[1, 5]
- ☐ UMP Plus—UW Medicine Accountable Care Network[1, 5]

[1] 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.

[2] Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

[3] 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.

[4] If you cover dependents not enrolled in Medicare Part A and Part B, you must also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.

[5] These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate their PEBB coverage to enroll in this plan. They will not be eligible for COBRA or other continuation coverage options.

[6] Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

[7] This plan is available only if at least one member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA Medicare Plan.

[8] Also submit Form B to enroll in Premera Blue Cross Medicare Supplement Plan G.

2020 PEBB Retiree Coverage Election Form

Subscriber's last name

Subscriber's Social Security number

Section 4 Dental plan selection *See instruction sheet for more information.*

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 during the PEBB Program's annual open enrollment (November 1 through 30) or due to a special open enrollment event. Before you select a dental plan, call the plan to make sure your provider accepts the specific plan and plan group.

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.

☐ 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.

Section 5 Retiree term life insurance election

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 *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.

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

2020 PEBB Program medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388
Medicare members: 1-888-901-4600

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

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

2020 PEBB Program dental contractors

DeltaCare, *administered by Delta Dental of Washington*
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-650-1583

Uniform Dental Plan, *administered by Delta Dental of Washington*
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124
1-855-4DENTAL (1-855-433-6825)

2020 PEBB Program life insurance contractor

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

Subscriber's last name

Subscriber's Social Security number

Section 6 Payment authorization *See instruction sheet for more information.*

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) no later than 45 days after your 60-day election period ends. If we do not receive your first payment by this deadline, we will not enroll you. You may lose your right to enroll in PEBB retiree insurance coverage.

How to make the first payment

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 (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.

If you select Electronic Debit Service (EDS) or invoicing below, make your check payable to Health Care Authority. Send it with your EDS form to:

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

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

- ☐ **Pension deduction:** I authorize DRS to deduct medical and dental (if elected) premiums, retiree term life insurance (if elected) premiums 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.
- ☐ **Electronic Debit Service (EDS):** I will submit the *2020 PEBB Electronic Debit Service Agreement* available in the *2020 PEBB Retiree Enrollment Guide*. I will pay my monthly premiums and 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.
- ☐ **Invoicing:** I will pay my medical and dental (if elected) 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.

Note: You cannot have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage, COBRA, or continuation coverage ended. Premiums and applicable premium surcharges are for a full month of coverage and cannot be prorated for a partial month, including when a member dies or terminates coverage before the end of the month. Payments are processed immediately as required by state law.

Continue to Section 7 to sign and complete this form. To add or remove dependents, also complete Section 8.

Questions? Visit **hca.wa.gov/pebb-retirees** or call us at 1-800-200-1004.

Subscriber's last name

Subscriber's Social Security number

Section 7 **Signature** *See instruction sheet for more information.*

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 it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company 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 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 entitled to 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 (November 1 through 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 *2020 PEBB Retiree Coverage Election Form* (form A) to enroll or defer enrollment in PEBB retiree health plan 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 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 **hca.wa.gov/pebb-retirees**.

Subscriber's signature

Date / /

Please sign, date, and keep a copy for your records. Mail the completed form and documentation to the Washington State Health Care Authority, PEBB Program, PO Box 42684, Olympia, WA 98504-2684, or fax to 360-725-0771.

Subscriber's last name

Subscriber's Social Security number

Section 8 Dependent information *See instruction sheet for more information.*

Relationship to subscriber

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

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex ☐ M ☐ F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Is this person enrolled in Part(s) A and/or B of Medicare?
If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) ☐ Yes ☐ No

If yes, effective date

Part B (medical) ☐ Yes ☐ No

If yes, effective date

If your dependent is entitled to 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

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No

If yes, effective date

Does this person receive Social Security Disability?

☐ Yes ☐ No

If yes, effective date

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

Tobacco use premium surcharge
Does the tobacco use premium surcharge apply to this dependent? Check one.

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

☐ **No, I am not subject to the $25 premium surcharge.**
This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Subscriber's Social Security number

Section 8 Dependent information *See instruction sheet for more information.*

Relationship to subscriber

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

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex ☐ M ☐ F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Is this person enrolled in Part(s) A and/or B of Medicare? If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) ☐ Yes ☐ No

If yes, effective date

Part B (medical) ☐ Yes ☐ No

If yes, effective date

If your dependent is entitled to 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

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No

If yes, effective date

Does this person receive Social Security Disability?

☐ Yes ☐ No

If yes, effective date

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

Tobacco use premium surcharge

Does the tobacco use premium surcharge apply to this dependent? Check one.

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

☐ **No, I am not subject to the $25 premium surcharge.**
This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Subscriber's Social Security number

Section 8 Dependent information *See instruction sheet for more information.*

Relationship to subscriber

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

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex ☐ M ☐ F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Is this person enrolled in Part(s) A and/or B of Medicare?
If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) ☐ Yes ☐ No

If yes, effective date

Part B (medical) ☐ Yes ☐ No

If yes, effective date

If your dependent is entitled to 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

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No

If yes, effective date

Does this person receive Social Security Disability?

☐ Yes ☐ No

If yes, effective date

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

Tobacco use premium surcharge
Does the tobacco use premium surcharge apply to this dependent? Check one.

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

☐ **No, I am not subject to the $25 premium surcharge.**
This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Instructions for Completing Form A

A

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

Note: If you wish to make a change to an existing retiree account, please use the *2020 PEBB Retiree Coverage Change Form* (form E).

! Remember to read and sign page 9. To enroll dependents, fill out Section 8 starting on page 10.

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	**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 *2020 PEBB Retiree Enrollment Guide* or visit **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 applying to enroll or defer (postpone) enrollment	**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) applying to enroll or defer (postpone) enrollment	• 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 insurance coverage ends. • For an eligible survivor of a school employee who passes away, **no later than 60 days** after the later of the date of the school employee's death or the date your SEBB or Washington State educational service district insurance 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	In most cases, **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 submit with Form A

If you are enrolling...	You must also submit...
In Premera Blue Cross Medicare Supplement Plan G	*Group Medicare Supplement Enrollment Application* (form B)
In a Medicare Advantage plan	*2020 PEBB Medicare Advantage Plan Election Form* (form C)
A state-registered domestic partner, the partner's child, or an extended dependent	*2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b)
A dependent child with a disability age 26 or older	*2020 PEBB Certification of a Child With a Disability* form. Return it as instructed on the form.
An extended dependent	*2020 PEBB Extended Dependent Certification* form

When to submit dependent verification documents

- You (the subscriber) are not enrolled in Medicare Part A and Part B, and you are enrolling a dependent.
- You are enrolling a state-registered domestic partner or their dependents (regardless of your Medicare enrollment status).

A list of documents we will accept to verify your dependent's eligibility is available in the *2020 PEBB Retiree Enrollment Guide* or at **hca.wa.gov/pebb-retirees**.

How to submit your completed enrollment forms and documentation

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 at **hca.wa.gov/fuze-questions**. You must date any forms you attach to a secure message.

How to submit your first premium payment

! A first payment is required even if you choose electronic debit service.

Unless you choose to have your premiums deducted from your Department of Retirement Systems pension, you must make the first premium payment with applicable premium surcharges before we will enroll you. Your first payment is due **no later than 45 days** after your 60-day election period ends. If we do not receive your first payment by this deadline, you will not be enrolled. You may lose your right to enroll in PEBB retiree insurance coverage.

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

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

Required — Retiree or employee information only

Print the name of the retiree, their 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 182-12-109), 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.

Section 1 — Subscriber information and enrollment

Print your (the retiree's) information in the subscriber section.

Tobacco use premium surcharge: Only complete this section if you are **not** enrolled in Medicare Part A and Part B. If you check **Yes** or leave this section blank, you will be charged the premium surcharge. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**.

Check your enrollment choice. You can enroll or defer.

Enroll: If you are enrolling, check the appropriate box(es).

Defer: If you are deferring (postponing) coverage or enrolling after deferring, check the appropriate box(es) and identify the deferral reason(s). The reasons listed are the **only** reasons you can defer enrollment in a PEBB retiree health plan.

Medicare enrollment: Check the appropriate boxes to indicate your Medicare enrollment status.

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 182-12-109).

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. **All subscribers:** If enrolling a state-registered domestic partner, please attach proof of eligibility and a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b).

Medicare enrollment: Check the appropriate boxes to indicate the Medicare enrollment status for your spouse or state-registered domestic partner.

Tobacco use premium surcharge: Only complete this section if you are **not** enrolled in Medicare Part A and Part B. If you check **Yes** or leave this section blank, you will be charged the premium surcharge. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**.

Spouse or state-registered domestic partner coverage premium surcharge: For help determining this surcharge applies to you, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* in the back of the *2020 PEBB Retiree Enrollment Guide*. You can also visit **hca.wa.gov/pebb-retirees** and click on *Surcharges* for more information.

Section 3 — Medical plan selection

Check the box for the medical plan you wish to enroll in. You may need to submit additional forms, which are listed on page 2 of these instructions.

Section 4 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 WAC 182-12-208.

Section 5 Retiree Term Life election

Only complete this section if you are enrolling in Retiree Term Life Insurance. You must also submit the *PEBB 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 find that you are not eligible for retiree term life insurance, we will send you a denial letter with your appeal rights.

Section 6 Payment authorization

Choose the method for your first premium payment, including applicable premium surcharges. **Read this section carefully, as your first payment may be required to begin coverage.** Your first payment is due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends. If we do not receive your payment by this deadline, we will not enroll you, and you may lose your right to enroll in PEBB retiree insurance coverage. If you choose Electronic Debit Service (EDS), also submit the *2020 PEBB Electronic Debit Service Agreement* form. Mail your payment and the EDS form, if elected, to the address listed in this section.

Section 7 Signature

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

Section 8 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 eligibility for each dependent within the PEBB Program's enrollment timelines.

- If enrolling a state-registered domestic partner's child, also submit the *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).
- If enrolling a dependent child with a disability age 26 or older, also submit the *2020 PEBB Certification of a Child With a Disability* form and return it as instructed on the form.
- If enrolling an extended dependent, also submit the *2020 PEBB Extended Dependent Certification* form and the *2020 PEBB Declaration of Tax Status* form.

Medicare enrollment: Check the appropriate boxes to indicate the Medicare enrollment status for your dependent.

Tobacco use premium surcharge: Only complete this section if you are **not** enrolled in Medicare Part A and Part B. Responses are only required for dependents age 13 or older. If you check **Yes** or leave this section blank, you will be charged the premium surcharge. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**.