HCA | Health Care Authority
Public Employees Benefits Board

2027 PEBB Employee Enrollment/Change form for medical-only groups

Clear form

Download and save this form first. Do not complete it in a web browser.

Use this form to enroll in medical coverage if you are unable to use Benefits 24/7 at **benefits247.hca.wa.gov**. Visit **hca.wa.gov/pebb-employee** for information about enrolling in other benefits.

You must complete the entire form, including the dependent section for any children you want to continue to cover. Inaccurate, incomplete, or illegible information may delay coverage.

All members who are eligible for enrollment in both the PEBB Program and the School Employees Benefits Board (SEBB) Program must choose health plan enrollment through one program. Choosing some plans in both programs is not allowed.

You and any dependents on your account cannot be enrolled in two PEBB accounts at the same time. If needed, ask your payroll or benefits office for help.

⚠ **Remember to read and sign Section 6.**

1 Subscriber

⚠ If you have a name, address, or phone number change, contact your payroll or benefits office.

Social Security number

Date of dob (mm/dd/yyyy)

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different from above)

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

⚠ If you waive medical coverage, you cannot enroll your dependents in medical. You can waive medical coverage if you are enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B.

Medical coverage

☐ Cover

☐ Waive

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The PEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. Refer to the *PEBB Employee Enrollment Guide* or visit HCA's website at **hca.wa.gov/pebb-employee** for more information.

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

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

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

☐ **No**, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources.

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

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

List your spouse or SRDP you wish to enroll or remove from coverage. SRDP is defined in WAC 182-12-109 and includes partners of legal unions from another jurisdiction that are 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 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 documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-employee**.

If your spouse or SRDP is eligible to enroll in both the PEBB and SEBB Programs, they are limited to a single enrollment in medical, and if applicable, dental and vision plans from either the PEBB Program or the SEBB Program as described in WAC 182-12-123. They may not enroll in health plans in both programs.

⚠ **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

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Medical coverage

Cover

Remove from coverage

If removing coverage, include reason:

1 This field is required for health care services.

Subscriber's last name

Social Security number

Tobacco use premium surcharge

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

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

☐ **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 has enrolled in or accessed one of the tobacco cessation resources.

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

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

Answer these questions for your spouse or SRDP in 2027:

1. Are you covering your spouse or SRDP in a PEBB medical plan?
   ☐ Yes ☐ No
2. Will they be eligible for medical coverage through their employer? (If they will not be employed, answer No.)
   ☐ Yes ☐ No
3. Will their employer offer at least one medical plan that serves their county of residence?
   ☐ Yes ☐ No
4. Have they chosen not to enroll in their employer's medical coverage?
   ☐ Yes ☐ No
5. Will the coverage offered by their employer **not** be through the PEBB 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 below. You will not be charged the surcharge.
If you answered Yes to all of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:
   a. Serve their county of residence.
   b. Have a monthly premium of less than $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-employee** under *Surcharges.*

⚠ **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:

☐ **Yes**, I am subject to the $50 premium surcharge. I completed the *PEBB Spousal Plan Calculator*.

☐ **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator.*

☐ I need my employer to determine if the premium surcharge applies. I am submitting a printed *PEBB Spousal Plan Calculator*.

Subscriber's last name

Social Security number

3 Dependents

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

List dependents you wish to enroll or remove from coverage. They must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday (regardless of marital status, student status, or eligibility for coverage under another plan) and children age 26 or older with a disability.

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-employee.**

If they are eligible to enroll in both the PEBB and SEBB Programs, they are limited to a single enrollment in medical, and if applicable, dental and vision from either the PEBB Program or SEBB Program as described in WAC 182-12-123. They may not enroll in both programs.

Additional forms for dependents

If enrolling:

- A state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.
- An extended dependent, submit a *PEBB Extended Dependent Certification*.
- A child with a disability age 26 or older, submit a *PEBB Certification of a Child with a Disability*.

⚠ **If adding more dependents, copy the dependents section and attach to this form.**

Relationship to subscriber

- ☐ Child
- ☐ Stepchild (not legally adopted)
- ☐ Extended dependent (attach a copy of the 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)

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

Medical coverage

☐ Cover

☐ Remove from coverage

If removing coverage, include reason:

Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 or older in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See page 2 for instructions on how to respond.

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

☐ **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 one of the tobacco cessation resources.

4 Medical plan selection

Choose one medical plan. Information about medical plan options can be found on HCA's website at **hca.wa.gov/pebb-employee**. 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.

Kaiser Foundation Health Plan of the Northwest (Kaiser Permanente NW)

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

☐ Kaiser Permanente NW Classic

☐ Kaiser Permanente NW Consumer-Directed Health Plan

Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)

☐ Kaiser Permanente WA Classic

☐ Kaiser Permanente WA Consumer-Directed Health Plan

☐ Kaiser Permanente WA SoundChoice

☐ Kaiser Permanente WA Value

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

☐ UMP Classic

☐ UMP Select

☐ UMP Consumer-Directed Health Plan

⚠ **If you are eligible for PEBB benefits but do not waive or enroll in PEBB medical coverage, you will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic. Your dependents will not be enrolled. You will be charged a monthly premium for medical coverage as well as a $25 monthly tobacco use premium surcharge.**

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

Subscriber's last name

Social Security number

5 Account changes and special open enrollment

Are you making changes to an existing account?

☐ Yes If Yes, what changes? (Check all changes that apply in the sections below.)

Date of event/change:

☐ No If No, go to the next section.

Annual open enrollment changes

All changes become effective **January 1 of the following year**.

Special open enrollment changes

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment (SOE) for the employee, a dependent, or both. Your payroll or benefits office must receive this form and proof of the event **no later than 60 days** after the event occurs. See "What is a special open enrollment" on the HCA website at **hca.wa.gov/pebb-employee** under *Manage benefits* for a list of documents to submit as proof of the event.

In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later. If that day is the first of the month, the change begins on that day.

⚠ Many SOE events have restrictions on allowed changes. See PEBB Policy Addendum 45-2A on the *PEBB Rules and policies* webpage at **hca.wa.gov/pebb-rules** for details. If you need assistance, contact your payroll or benefits office.

Check the box next to the change you are requesting:

☐ Add dependents

☐ Remove dependents. If removing due to loss of eligibility (divorce, annulment, dissolution, or dependent no longer eligible as a child), your payroll or benefits office must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility for health plan coverage. If applicable, provide the former dependent's new address:

Street address

Address line 2

City State

ZIP/Postal code County

☐ Change medical plan

☐ Enroll after waiving medical coverage

☐ Waive medical due to enrollment in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B.

Note: To change health plans when you are adding an SRDP or their child, the person you are adding must be a tax dependent.

Subscriber's last name

Social Security number

Check the box next to the reason for the change:

- ☐ Annual open enrollment
- ☐ Marriage or registering a state-registered domestic partnership
- ☐ Birth, adoption, or assuming a legal obligation for support in anticipation of adoption
- ☐ Newly eligible extended dependent
- ☐ Court-ordered coverage of dependents
- ☐ Loss of other coverage
- ☐ You have a change in employment status
- ☐ Your dependent has a change in their employment status
- ☐ Change in enrollment under other employer-based group health plan's open enrollment
- ☐ Enroll in or lose eligibility for Medicare
- ☐ Become eligible and enroll in or lose eligibility for a TRICARE plan
- ☐ Change in residence that affects health plan availability
- ☐ Change in country of residence for dependent
- ☐ Medical plan becomes unavailable
- ☐ Enroll in or lose eligibility for coverage under Medicaid (called Apple Health in Washington state) or a Children's Health Insurance Program (CHIP) coverage
- ☐ Become eligible for state premium assistance subsidy
- ☐ Continuity of care (requires approval by the PEBB Program)
- ☐ Other, explain:

Subscriber's last name

Social Security number

6 Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans or premiums paid on my behalf. My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility. 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 adding a state-registered domestic partner (SRDP) to my account, I declare that my domestic partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until the PEBB Program verifies the eligibility of my dependents. I understand if I'm applying to add a dependent to my PEBB insurance coverage, I must provide copies of documents that verify the dependent's eligibility within the PEBB Program's enrollment timelines, or the dependent will not be enrolled.

If I am eligible for the employer contribution toward PEBB benefits but do not waive or enroll in PEBB Program medical coverage, I will be enrolled automatically as a single subscriber in Uniform Medical Plan (UMP) Classic. My dependents will not be enrolled. I will be charged a monthly premium for medical coverage as well as a $25 monthly tobacco use premium surcharge.

Employees who choose to waive PEBB medical coverage must be enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B, though employees may not enroll in SEBB medical with a SEBB-participating employer group that offers only medical coverage. If I waive medical coverage, I understand I can enroll during annual open enrollment or **no later than 60 days** after a special open enrollment event as defined in PEBB Program rules. If I waive medical coverage for myself, I cannot enroll my dependents in medical coverage.

I allow my employer to deduct money from my earnings to pay for insurance coverage and applicable premium surcharges. I understand I am responsible for paying applicable tobacco use premium surcharges and spouse or SRDP coverage premium surcharges in addition to my monthly medical premium.

If I enroll in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility criteria. I understand that my employer will contribute to an HSA on my behalf based on the information I have provided, and there are limits to these contributions and my HSA contributions (if any) under federal tax law.

I understand that my enrollment and my dependents' enrollment are subject to me abiding by 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.

This form replaces all enrollment forms previously submitted, including any changes made in the online enrollment system.

Sign, date, and return form and any required documentation to your payroll or benefits office.

Subscriber's signature

Date

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, contact your payroll or benefits office.

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-employee**.

Subscriber's last name

Social Security number

7 Employer

⚠ This section to be completed by your employer.

Agency name

Agency/subagency

Eligibility date

Insurance effective date

Represented?

☐ Yes ☐ No

If yes, date they became represented (mm/dd/yyyy):

PEBB Program medical contractors

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

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-5398
1-800-813-2000 (TRS: 711)

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

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

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