

2017 Retiree Coverage Election/Change (Open Enrollment)

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **List eligible family members you wish to cover or remove from coverage. This form replaces all retiree coverage election forms previously submitted.**
- **If deferring PEBB Program retiree coverage, complete required sections below and Sections 1 and 7.**
- If enrolling a dependent with a disability age 26 or older, submit a completed *Certification of Dependent with a Disability* form and return as instructed on the form. Attach an *Extended Dependent Certification* form if enrolling an extended dependent.
- If you are a retiree not enrolled in Medicare Part A and Part B and adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled. A list of documents we will accept to show proof of eligibility is in the *2017 Retiree Enrollment Guide*, available at www.hca.wa.gov/public-employee-benefits.
- If you are a surviving spouse, surviving state-registered domestic partner defined in WAC 182-12-260(2), or surviving dependent, provide the Social Security number (SSN) of the deceased retiree or employee in the "Retiree or employee information only" section below. Provide your SSN and fill out information in Section 1: Subscriber Information.

Required Retiree or employee information only	Retiree or employee name	
	Social Security number	
Required Additions or changes <i>Check all that apply.</i>	What change are you requesting? <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan	
	Change in coverage: <input type="checkbox"/> Cancel enrollment <input type="checkbox"/> Defer enrollment <i>See Section 1 (page 2) and Section 7 (page 7) of this form.</i>	Change in family status: <input type="checkbox"/> Remove a spouse or dependent. <input type="checkbox"/> Add a spouse. <input type="checkbox"/> Add a state-registered domestic partner. Attach a <i>Declaration of Tax Status</i> form. <input type="checkbox"/> Add family member(s). Attach a <i>Declaration of Tax Status</i> form for children of state-registered domestic partners.

Section 1: Subscriber Information					
Social Security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> 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 (including area code) ()	Alternate phone number (including area code) ()		

(continued)

HCA is committed to providing equal access to our services.
 If you need an accommodation, or require documents in another format, please call 1-800-200-1004.
 People who have hearing or speech disabilities please call 711 for relay services

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Subscriber's last name	First name	Middle initial	Social Security number
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Section 1: Enrollment Election/Change *(continued from page 1)*. Check the boxes that apply to you.

Enroll: Medical only Medical and dental

Cancel: I am enrolled in PEBB Program retiree coverage; I want to make the following change(s):

- Cancel medical (if enrolled in only medical) and dental coverage (if enrolled in both).
Cancel date: _____ I understand I am forfeiting all further rights to enroll again unless I regain eligibility. Coverage is automatically canceled for any enrolled dependents.
- Cancel dental coverage for myself and any dependents.
Cancel date: _____ I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB retiree dental plan for at least two years or if I am deferring or disenrolling from my PEBB Program coverage as allowed under PEBB Program rules (see Section 5). If I cancel dental for myself, dental is automatically canceled for my enrolled dependents.
- Cancel retiree term life insurance.

Defer my coverage. Identify below the medical coverage allowing you to defer PEBB Program retiree coverage. See also Section 7. Except as stated below, this defers coverage for all family members.

Deferral date _____

Enroll after deferring coverage. Identify below the medical coverage you have been enrolled in since deferring enrollment in PEBB Program retiree coverage.

Date other coverage ended _____

If deferring or enrolling after deferring, check the box below that applies to you. When enrolling after deferring, you must provide proof of continuous coverage since your date of deferral.

- 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 Medicare Part A **and** Part B **and** a Medicaid program that provides creditable coverage. (You may continue to cover eligible family members who are not eligible for creditable coverage under Medicaid.)
- Enrolled in medical coverage as a retiree or dependent in TRICARE or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in PEBB Program coverage.
- Non-Medicare retirees only: Enrolled in qualified health plan coverage through a health benefits 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 PEBB Program retiree coverage.

Enrolled in Part(s) A and/or B of Medicare?
If yes, proof is required. Attach a copy of your Medicare card to this election form if we don't already have a copy.

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

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

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

Yes No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D?

Yes No If yes, effective date _____

Receiving Social Security Disability?

Yes No If yes, effective date _____

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly \$25-per-account surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B and you or a family member (age 13 or older) enrolled on your PEBB Program medical coverage 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 below or leave this section blank, you will pay the surcharge. See the 2017 Premium Surcharge Help Sheet at www.hca.wa.gov/public-employee-benefits for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Read each option carefully and check only one:

I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

YES, I am subject to the \$25 surcharge. I have used tobacco products in the past two months.

NO, I am not subject to the \$25 surcharge. I have not used tobacco products in the past two months, or I have used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

2017 Retiree Coverage Election/Change (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social Security number
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Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner (as defined in WAC 182-12-260(2)) you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB Program medical or dental accounts at the same time. **If you are not enrolled in Medicare Part A and Part B, you must provide proof of eligibility within PEBB's enrollment timelines to enroll a spouse or state-registered domestic partner.**

Relationship to subscriber. If adding a state-registered domestic partner, please attach a completed *Declaration of Tax Status* form and proof of eligibility within PEBB's enrollment timelines.

Spouse: date of marriage _____ State-registered domestic partner: date registered _____

Social Security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street address (only if different from subscriber)	Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy) _____

Coverage for spouse or state-registered domestic partner
 Cover Remove Effective date _____ Reason _____
 Attach a copy of divorce decree or dissolution of state-registered domestic partnership if removing spouse or state-registered domestic partner for this reason.

Enrolled in Part(s) A and/or B of Medicare?

If yes, proof is required. Attach a copy of the spouse or state-registered domestic partner's Medicare card to this form.

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

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

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

Yes No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D?

Yes No If yes, effective date _____

Receiving Social Security Disability?

Yes No If yes, effective date _____

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Read each option and check only one:

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

YES, I am subject to the \$25 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 surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the *2017 Premium Surcharge Help Sheet*.

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly \$50 surcharge in addition to your 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 other employer-based group medical that is comparable to Uniform Medical Plan Classic. See the 2017 Premium Surcharge Help Sheet in your enrollment packet or at www.hca.wa.gov/public-employee-benefits for instructions.

If you check YES below or leave this section blank, you will pay the monthly surcharge.

Does the spouse or state-registered domestic partner coverage surcharge apply to you? Read each option carefully and check only one:

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

YES, I am subject to the \$50 surcharge. I used the *2017 Premium Surcharge Help Sheet* and completed the *2017 Spousal Plan Calculator*.

NO, I am not subject to the \$50 surcharge. I used the *2017 Premium Surcharge Help Sheet* (and, if needed, completed the *2017 Spousal Plan Calculator* online.)

Which questions (if any) on the 2017 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

PEBB Program to determine. I am completing and submitting the *2017 Spousal Plan Calculator* found at www.hca.wa.gov/public-employee-benefits.

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2017 Retiree Coverage Election/Change (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social Security number
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Section 3: Family Member Information. Use additional forms for more members.

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB Program medical or dental accounts at the same time. **If you are not enrolled in Medicare Part A and Part B, you must provide proof of your family member's eligibility within the PEBB Program's enrollment timelines or your family member will not be enrolled.** If enrolling a state-registered domestic partner's child, attach a completed Declaration of Tax Status form. If enrolling a dependent with a disability age 26 or older, submit a completed Certification of Dependent with a Disability form and return as instructed on the form. Attach an Extended Dependent Certification form if enrolling an extended dependent.

1	Relationship to subscriber	Last name	First name	Middle initial	
	Social Security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	(Check only if age 26 or older) Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Extended dependent validated by court order? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street address (only if different from subscriber)		Apt./unit number	City	State	ZIP Code

Coverage for family member

Cover Remove Effective Date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare? Part A (hospital) Yes No If yes, effective date _____
If yes, proof is required. Attach a copy of family member's Medicare card to this form. Part B (medical) Yes No If yes, effective date _____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. Yes No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? Yes No If yes, effective date _____

Receiving Social Security Disability? Yes No If yes, effective date _____

Does the tobacco use premium surcharge apply to this family member? Response required for family members ages 13 or older. Read each option carefully and check only one:

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

YES, I am subject to the \$25 surcharge. This family member has used tobacco products in the past two months.

NO, I am not subject to the \$25 surcharge. This family member has not used tobacco products in the last two months, or has used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

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2017 Retiree Coverage Election/Change (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social Security number
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Section 3 (cont.): Family Member Information. Use additional forms for more members.

2	Relationship to subscriber	Last name	First name	Middle initial
Social Security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	(Check only if age 26 or older) Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Extended dependent validated by court order? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street address (only if different from subscriber)		Apt./unit number	City	State
				ZIP Code

Coverage for family member

Cover Remove Effective Date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare? Part A (hospital) Yes No If yes, effective date _____
 If yes, proof is required. Attach a copy of your family member's Medicare card to this form. Part B (medical) Yes No If yes, effective date _____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. Yes No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? Yes No If yes, effective date _____

Receiving Social Security Disability? Yes No If yes, effective date _____

Does the tobacco use premium surcharge apply to this family member? Response required for family members ages 13 or older. Read each option carefully and check only one:

- The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- YES, I am subject to the \$25 surcharge.** This family member has used tobacco products in the past two months.
- NO, I am not subject to the \$25 surcharge.** This family member has not used tobacco products in the last two months, or has used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

Section 4: Medical Plan Selection Check appropriate box(es).

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative

- Group Health Classic
 Group Health Medicare Plan^{1,2}
 Group Health SoundChoice³
 Group Health Value

Group Health Options Inc.

- Group Health Consumer-Directed Health Plan⁴

Kaiser Foundation Health Plan of the Northwest

- Kaiser Permanente Classic
 Kaiser Permanente Consumer-Directed Health Plan⁴
 Kaiser Permanente Senior Advantage¹

Medicare Supplement Plan F, administered by Premera Blue Cross⁵

Uniform Medical Plan, administered by Regence BlueShield

- UMP Classic
 UMP Consumer-Directed Health Plan⁴

UMP Plus⁶ (select one network below)

- UMP Plus-Puget Sound High Value Network⁶
 UMP Plus-UW Medicine Accountable Care Network⁶

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 family members not enrolled in Medicare Part A and Part B, also select Group Health Classic, SoundChoice, or Value for these family members.

³ This plan is available only if at least one covered family member is not enrolled in Medicare Part A and Part B. Family members enrolled in Medicare Part A and Part B will be enrolled in Group Health's Medicare Plan.

⁴ These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB Program coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation of coverage options.

⁵ Also complete and return form B to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.

⁶ This plan is not available to Medicare Part A and Part B retirees and their dependents.

2017 Retiree Coverage Election/Change (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social Security number
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Section 5: Dental Plan Selection *Check only one. You must enroll in medical coverage to enroll in dental.*

If you select retiree dental coverage for yourself, **you must keep dental coverage for yourself and any enrolled dependents for at least two years.** However, you may change retiree dental plans within those two years during the annual PEBB Program open enrollment, or due to a special open enrollment event.

Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans for benefits information; their contact information is located at the end of this form.

Preferred Provider Organization

- Uniform Dental Plan, administered by **Delta Dental of Washington (Group #3000)**
You can choose any dental provider and change providers at anytime.

Managed-Care Plans

- DeltaCare, administered by **Delta Dental of Washington (Group #3100)**
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 network 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.

Cancel Dental

I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB retiree dental plan for at least two years or if I am deferring or disenrolling from my PEBB Program coverage as allowed under PEBB Program rules (see also Section 7). If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

Section 6: Payment Authorization

How would you like to pay your premiums and any applicable surcharges?

- I wish to continue my current payment method.
- I wish to change my payment method to:
- Pension deduction:** I authorize the Department of Retirement Systems to deduct medical, dental, and retiree term life insurance premiums (if currently enrolled) and any applicable surcharges I am required to pay from my retirement pension. Deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.
 - Invoicing:** I want to receive a bill and will pay my medical and dental (if elected) premium and any applicable surcharges monthly by check. If I am currently enrolled in retiree term life insurance, I understand I will receive a separate bill from MetLife for my retiree term life insurance monthly premium.
 - Electronic Debit Service (EDS):** I will pay my monthly medical and dental (if elected) premium and any applicable surcharges by EDS. I will complete and submit the *Electronic Debit Service Agreement* available at www.hca.wa.gov/public-employee-benefits. I understand I must pay as invoiced until I am notified of my EDS effective date.

If you are currently enrolled in retiree term life insurance: Unless you are paying by pension deduction, you will begin receiving a separate bill/invoice from MetLife for your retiree term life insurance premiums. To pay by EDS, contact MetLife at 1-866-548-7139.

(continued)

2017 Retiree Coverage Election/Change (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social Security number
Section 7: Signature <i>Required</i>			
<p>By signing 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 law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB Program 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 program benefits.</p> <p>If I send payment, this does not mean I will be automatically enrolled in PEBB Program insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund of premium payments.</p> <p>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).</p> <p>I understand if I enroll in PEBB Program 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 continued under COBRA as an employee or dependent of an employee.</p> <p>I understand if I or any enrolled family member is entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.</p> <p>If I choose to defer medical/dental, I understand I can enroll or reenroll no later than 60 days after losing other health coverage or during the PEBB Program annual open enrollment period as long as there has been no gap in coverage and I provide proof of continuous enrollment. If I defer enrollment for myself, I cannot enroll my eligible family members. 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.</p> <p>If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that 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.</p> <p>If I die, my eligible surviving family members must complete the <i>Retiree Coverage Election/Change</i> form to enroll in or defer PEBB Program retiree health insurance coverage. The PEBB Program must receive the form no later than 60 days after my death.</p> <p>This form replaces all <i>Retiree Coverage Election</i> forms previously submitted to the PEBB Program. All changes noted on this form become effective January 1, 2017.</p> <p>If I am a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with the DRS to better serve me.</p> <p>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/public-employee-benefits.</p> <p>Subscriber's signature _____ Date _____</p>			
<p>Be sure to sign and date this form. Mail completed form and documentation to: Washington State Health Care Authority, PEBB Program, P.O. Box 42684, Olympia, WA 98504-2684 or fax to: 360-725-0771</p> <p>Questions? Visit our website at www.hca.wa.gov/public-employee-benefits or call us at 1-800-200-1004.</p>			

2017 PEBB Program Medical Contractors

Group Health Cooperative

320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
 1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc.

320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
 1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest

500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
 1-800-813-2000 or TTY 711

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 TTY 711

2017 PEBB Program Dental Contractors

DeltaCare, administered by Delta Dental of Washington

9706 Fourth Avenue NE, Seattle, WA 98115-2157
 1-800-650-1583

Uniform Dental Plan,

administered by Delta Dental of Washington

9706 Fourth Avenue NE, Seattle, WA 98115-2157
 1-800-537-3406

Willamette Dental of Washington, Inc.

6950 NE Campus Way, Hillsboro, OR 97124-5611
 1-855-433-6825

2017 Retiree Coverage Election/Change (Open Enrollment)

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- **List eligible family members you wish to cover or remove from coverage. This form replaces all retiree coverage election forms previously submitted.**
- **If deferring PEBB Program retiree coverage, complete required sections below and Sections 1 and 7.**
- If enrolling a dependent with a disability age 26 or older, submit a completed *Certification of Dependent with a Disability* form and return as instructed on the form. Attach an *Extended Dependent Certification* form if enrolling an extended dependent.
- If you are a retiree not enrolled in Medicare Part A and Part B and adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled. A list of documents we will accept to show proof of eligibility is in the *2017 Retiree Enrollment Guide*, available at www.hca.wa.gov/public-employee-benefits.
- If you are a surviving spouse, surviving state-registered domestic partner defined in WAC 182-12-260(2), or surviving dependent, provide the Social Security number (SSN) of the deceased retiree or employee in the "Retiree or employee information only" section below. Provide your SSN and fill out information in Section 1: Subscriber Information.

Required Retiree or employee information only	Retiree or employee name	
	Social Security number	
Required Additions or changes <i>Check all that apply.</i>	What change are you requesting? <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan	
	Change in coverage: <input type="checkbox"/> Cancel enrollment <input type="checkbox"/> Defer enrollment <i>See Section 1 (page 2) and Section 7 (page 7) of this form.</i>	Change in family status: <input type="checkbox"/> Remove a spouse or dependent. <input type="checkbox"/> Add a spouse. <input type="checkbox"/> Add a state-registered domestic partner. Attach a <i>Declaration of Tax Status</i> form. <input type="checkbox"/> Add family member(s). Attach a <i>Declaration of Tax Status</i> form for children of state-registered domestic partners.

Section 1: Subscriber Information					
Social Security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> 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 (including area code) ()		Alternate phone number (including area code) ()	

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HCA is committed to providing equal access to our services.
 If you need an accommodation, or require documents in another format, please call 1-800-200-1004.
 People who have hearing or speech disabilities please call 711 for relay services



P.O. Box 91120, MS 295
Seattle, WA 98111-9220

Group Medicare Supplement Enrollment Application Washington State Health Care Authority

You can become a Washington State Health Care Authority Medicare Supplement member if you:

- Are eligible for the group's Medicare supplement plan
- Currently have both Medicare Part A and Part B, **and**
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

For Office Use Only
Group Number: _____
Effective Date of Coverage: _____/_____/_____
Enrollee Class (if applicable): _____

Please PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted. PLEASE RETURN ALL THE PAGES OF THE APPLICATION EVEN IF THEY ARE BLANK.

A

Your Information

Applicant

I am eligible for Medicare Part A and B because: Age 65+ Under Age 65

I have Medicare due to: Kidney Dialysis or Kidney Transplant

Last Name		First Name		Middle Initial	Social Security Number (required)		
Home Address (cannot be a P.O. Box)				City	County	State	ZIP
Mailing Address (if different from above)				City	County	State	ZIP
Daytime Phone Number ()			Email Address				
Birthdate	Month	Day	Year	Gender			
				<input type="checkbox"/> Male	<input type="checkbox"/> Female		

Dependent

I am eligible for Medicare Part A and B because: Age 65+ Under Age 65

I have Medicare due to: Kidney Dialysis or Kidney Transplant

Relationship to Applicant: _____

Last Name		First Name		Middle Initial	Social Security Number (required)		
Home Address (cannot be a P.O. Box)				City	County	State	ZIP
Mailing Address (if different from above)				City	County	State	ZIP
Daytime Phone Number ()			Email Address				
Birthdate	Month	Day	Year	Gender			
				<input type="checkbox"/> Male	<input type="checkbox"/> Female		

B

What Plan Do You Want?

Which Medicare supplement plan do you want to enroll in?

Plan F

Did you receive a copy of the Premera Blue Cross "Outline of Coverage"?

Yes No

Did you receive a copy of Medicare's "Choosing A Medigap Policy" guide?

Yes No

C

Your Other Health Coverage

Please answer all the questions below as best you know how.

Applicant

Tell Us About Your Medicare Coverage (You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months?

Yes No

b. Did you enroll in Medicare Part B in the last 6 months?

Yes No

c. If **Yes**, what is the effective date? (month and year)

_____ / 01 / _____

(See your Medicare card to find this date.)

Your Medicare Information Here

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY	
MEDICARE CLAIM NUMBER	
_____ - _____ - _____ - _____	
IS ENTITLED TO	EFFECTIVE DATE
Part A Hospital Insurance	_____ / 01 / _____
Part B Medical Insurance	_____ / 01 / _____

Tell Us About Your Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?

Yes No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)

If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare

Supplement plan? (You can't keep both.)

Yes No

c. Was this your first time in this type of Medicare plan? Yes No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

Tell Us About Your Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave 3.b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) Yes No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) Yes No

Tell Us About Any Other Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). Yes No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program? **Note To Applicant:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. Yes No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? Yes No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? Yes No

Dependent

**Tell Us About Your Medicare Coverage
(You have to have Medicare Parts A and B to Enroll)**

1. a. Did you turn age 65 in the last 6 months? Yes No
- b. Did you enroll in Medicare Part B in the last 6 months? Yes No
- c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____
(See your Medicare card to find this date.)

Dependent's Medicare Information Here

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY	
MEDICARE CLAIM NUMBER	
_____ - _____ - _____ - _____	
IS ENTITLED TO	EFFECTIVE DATE
Part A Hospital Insurance	_____ / 01 / _____
Part B Medical Insurance	_____ / 01 / _____

Tell Us About Your Dependent's Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? Yes No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)

If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) Yes No
- c. Was this your first time in this type of Medicare plan? Yes No
- d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

Tell Us About Your Dependent's Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) Yes No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) Yes No

Tell Us About Any Other Dependent Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). Yes No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Dependent's Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program? **Note To Applicant:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. Yes No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? Yes No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? Yes No

Proceed to section D

D Conditions of Enrollment/Signatures

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true.

1. I am an eligible member of the group.
2. I have **both** Medicare Parts A and B in force today.
3. I understand that my coverage does not start until Premera accepts this application and assigns an effective date.
4. I authorize Premera, at its option, to pay doctors and other providers directly for health care I receive.
5. 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 insurance benefits.
6. I also understand and agree that Premera may cancel this coverage back to its start date as if I never had coverage at all, if it is found that I have supplied false information, or any information was omitted by me or for me, on this application, and that information is material enough to affect my eligibility for coverage. (Please note: After coverage has been in force for two years, coverage may no longer be canceled for this reason.)
7. I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions. Examples are to determine my eligibility for enrollment or to pay claims. If Premera discloses my personal information for any other reason, Premera will first take out any data that can be used to easily identify me, or will get my signed permission.

Be sure to sign and date this application, include all pages of the application and provide any proof required for “yes” answers in section C, when submitting to Premera for processing.

Signature of Applicant	Today's Date
X	

Signature of Dependent	Today's Date
X	

Please Note: If you have a Medicare supplement or Medicare Advantage policy today (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete the “Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage” form.

If you have any questions, please contact your benefit department or Premera at 1-800-817-3049 or TDD for the Deaf or Hard of Hearing at 1-800-842-5357.

Important Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this plan, you become entitled to Medicaid, the benefits and subscription charges under your Medicare Supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a “Qualified Medicare Beneficiary” (QMB) or a “Specified Low-Income Medicare Beneficiary” (SLMB).
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested within 90 days of losing your employer or union based group health plan.

Who Is Eligible For Coverage?

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be an eligible retiree and enroll during one of the periods listed below:

- In the 30-day period before you become eligible for Part A and Part B of Medicare
- Within six month of initial enrollment in Medicare Part B
- Within six months of attaining age 65
- Within 60 days of retirement.
- During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, and only if you are transferring from another health plan with no lapse in coverage. Note: Existing PEBB and K-12 subscribers may change their coverage by applying for another plan offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.
- Within 63 days of losing coverage under a retiree group health plan, a Medicare Advantage plan, a health care prepayment plan, a Program of All-Inclusive Care for the Elderly, a Medicare supplement or Medicare SELECT plan, or a Medicare risk or cost plan for reasons that qualify under federal law. Your answers in section C of the application will determine if you qualify.

Dependents of Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be an otherwise eligible spouse or state-registered domestic partner of the group retiree and enroll during one of the periods listed below:

- In the 30-day period before you become eligible for Part A and Part B of Medicare
- Within six month of initial enrollment in Medicare Part B
- Within six months of attaining age 65
- At the same time as the group retiree
- During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, and only if you are transferring from another health plan with no lapse in coverage.
- Within 63 days of losing coverage as described for PEBB and K-12 retirees above. Your answers in section C of the application will determine if you qualify.

State Residents

To be eligible, you must be a current Washington State resident and enroll during one of the periods listed below:

- In the 30-day period before you become eligible for Part A and Part B of Medicare
- Within six month of initial enrollment in Medicare Part B
- Within six months of attaining age 65
- Within 60 days of retirement. Retirement date: _____
- Within 60 days of establishing Washington State residency. Residency date: _____
- Within 63 days of losing coverage as described for PEBB and K-12 retirees above. Your answers in section C of the application will determine if you qualify.

Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማራኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ 800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):

本通知有重要的訊息。 本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):**Beeksisni kun odeeffannoo barbaachisaa qaba.**

Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):

Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):**Diese Benachrichtigung enthält wichtige**

Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-tyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese): この通知には重要な情報が含まれています。 この通知には、Premera Blue Crossの申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければなりません。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສະເພາະ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្លៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਈ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس با شماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):

To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):**Prezenta notificare conține informații importante.**

Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):**Настоящее уведомление содержит важную**

информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):**Ang Paunawa na ito ay naglalaman ng mahalagang**

impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).