

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) ()		

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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

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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*.

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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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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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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.

<p>Group Health Cooperative</p> <p><input type="checkbox"/> Group Health Classic</p> <p><input type="checkbox"/> Group Health Medicare Plan^{1,2}</p> <p><input type="checkbox"/> Group Health SoundChoice³</p> <p><input type="checkbox"/> Group Health Value</p> <p>Group Health Options Inc.</p> <p><input type="checkbox"/> Group Health Consumer-Directed Health Plan⁴</p> <p>Kaiser Foundation Health Plan of the Northwest</p> <p><input type="checkbox"/> Kaiser Permanente Classic</p> <p><input type="checkbox"/> Kaiser Permanente Consumer-Directed Health Plan⁴</p> <p><input type="checkbox"/> Kaiser Permanente Senior Advantage¹</p> <p><input type="checkbox"/> Medicare Supplement Plan F, administered by Premera Blue Cross⁵</p> <p>Uniform Medical Plan, administered by Regence BlueShield</p> <p><input type="checkbox"/> UMP Classic</p> <p><input type="checkbox"/> UMP Consumer-Directed Health Plan⁴</p> <p>UMP Plus⁶ (select one network below)</p> <p><input type="checkbox"/> UMP Plus-Puget Sound High Value Network⁶</p> <p><input type="checkbox"/> UMP Plus-UW Medicine Accountable Care Network⁶</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>⁶ This plan is not available to Medicare Part A and Part B retirees and their dependents.</p>
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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.

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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 align="center">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



PEBB Medicare Advantage Plan Disenrollment Form

This is a request to cancel enrollment in a PEBB Medicare Advantage plan.

(Please print in black ink.)

I wish to cancel enrollment in (check one):	
Group Health Cooperative <input type="checkbox"/> Group Health Medicare Advantage	Effective date of change / /
Kaiser Foundation Health Plan of the Northwest <input type="checkbox"/> Kaiser Permanente Senior Advantage	
<p>The Health Care Authority must process this form. Your enrollment in a Medicare Advantage plan will end on the last day of the month after your medical plan receives this completed form.</p> <p>If you are a retiree receiving benefits through the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS to better serve you.</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>	
Subscriber's name	Date / /
Subscriber's signature	
Medicare number	
Spouse or state-registered domestic partner's name	Date / /
Spouse or state-registered domestic partner's signature	
Medicare number	

2017 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
 1-888-901-4636 or TTY 711 or 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
 1-877-221-8221 or TTY 711

Please return this form by mail to:

Washington State Health Care Authority
 P.O. Box 42684
 Olympia, WA 98504-2684
or fax to: 360-725-0771

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