Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

# PEBB COVID-19 Enrollment/ Change Form

***Only for use from July 1 through 31, 2020***

In light of the COVID-19 pandemic, the PEBB Program is offering a limited open enrollment from July 1 through 31, 2020. Employees and most PEBB Continuation Coverage subscribers can enroll in medical coverage (if they are currently enrolled only in dental) and add dependents to their medical coverage. Employees of medical-only groups may also enroll in medical coverage if they previously waived.

**Please check the change(s) you would like to make:**

- ☐ Enroll in medical coverage
- ☐ Add dependent(s) to medical coverage

Clear form

Type or print clearly in dark ink and use only capital lettering inside the boxes as shown in the example. Inaccurate, incomplete, or illegible information may delay coverage.

Remember to sign and date page 6. To add dependents, fill out Section 6 starting on page 10

**Follow example to fill in form:**

J O H N

## Section 1 Subscriber information

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex ☐ M ☐ F

Phone number

Work phone number

Street address

Address line 2

City

State

ZIP Code

County of residence

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP Code

**If you are an employee, your employer will complete this section.**

Agency name:

Agency/subagency number:

Insurance effective date: August 1, 2020

## PEBB COVID-19 Enrollment/Change Form

Subscriber's last name

Subscriber's Social Security number

**If you are enrolled in PEBB Continuation Coverage (COBRA), complete the information below. If you are an employee, skip ahead to the "Spouse or state-registered domestic partner coverage premium surcharge" section.**

Covered by another group medical plan? ☐ Yes ☐ No If yes, effective date: / /

Covered by another group dental plan? ☐ Ye s ☐ No If yes, effective date: / /

Disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date: / /

Disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date: / /

If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part A (hospital)? ☐ Yes ☐ No If yes, effective date: / /

Enrolled in Medicare Part B (medical)? ☐ Yes ☐ No If yes, effective date: / /

If yes, proof is required. Attach a copy of your Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note**: You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

### Tobacco use premium surcharge

The PEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check **YES** or leave this section blank, you will be charged the $25 premium surcharge. See the *PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/erb** for instructions on how to respond.

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

☐ **YES**, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months. If this is a change to a previous attestation, indicate the date your tobacco use changed.
**Date of change (mm/dd/yyyy)**
/ /

☐ **NO**, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet.* The surcharge does not apply if you are a PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

Subscriber's last name

Subscriber's Social Security number

## Section 2 Spouse or state-registered domestic partner information

- Skip this section if you are not enrolling a spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-109.
- List an eligible spouse or state-registered domestic partner you wish to add to your PEBB medical coverage.
- All PEBB employees (and PEBB Continuation Coverage subscribers enrolling a state-registered domestic partner) must provide proof of each dependent's eligibility no later than July 31, 2020, or the dependent will not be enrolled. All forms and a list of documents we will accept to verify dependent eligibility are available at **hca.wa.gov/erb**.
- Dependents cannot be enrolled in two PEBB medical accounts at the same time.

Relationship to subscriber

☐ Spouse: date of marriage / /

☐ State-registered domestic partner: date registered / /
If adding a state-registered domestic partner, please attach a *PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

Last name

Suffix

First name

Middle initial

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

Social Security number – –

Sex ☐ M ☐ F

Street address

Address line 2

City

State

ZIP Code –

**If you are enrolled in PEBB Continuation Coverage (COBRA), complete the information below. If you are an employee, skip ahead to the "Tobacco use premium surcharge" section.**

| | | | |
|---|---|---|---|
| Covered by another group medical plan? | ☐ Yes | ☐ No | If yes, effective date: / / |
| Covered by another group dental plan? | ☐ Yes | ☐ No | If yes, effective date: / / |
| Disabled under Title II (OASDI) of the Social Security Act? | ☐ Yes | ☐ No | If yes, effective date: / / |
| Disabled under Title XVI (SSI) of the Social Security Act? | ☐ Yes | ☐ No | If yes, effective date: / / |

If yes, you must send a copy of your dependent's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

## PEBB COVID-19 Enrollment/Change Form

Subscriber's last name

Subscriber's Social Security number

Enrolled in Medicare Part A (hospital)? ☐ Yes ☐ No If yes, effective date: / /

Enrolled in Medicare Part B (medical)? ☐ Yes ☐ No If yes, effective date: / /

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note**: You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

### Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic. See the *PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. If you check **YES** below or leave this section blank, you will be charged the $50 premium surcharge. If you check **NO**, identify the questions you checked **NO** to.

The surcharge does not apply if you are a PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B; simply check **NO** below.

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

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

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

If **NO**, and you are not a PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B, which questions on the *PEBB Premium Surcharge Attestation Help Sheet* did you check **NO** (if any)? Check all that apply. (Question 1 is not applicable.)

☐ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

☑ **Employer (for employees) or the PEBB Program (for PEBB Continuation Coverage subscribers) to determine if premium surcharge applies.**

I used the *PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *PEBB Spousal Plan Calculator*. My employer or the PEBB Program, as appropriate, will use these to determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to PEBB's UMP Classic and if I am subject to the premium surcharge.

The *PEBB Premium Surcharge Attestation Help Sheet* and the *PEBB Spousal Plan Calculator* are available at **hca.wa.gov/erb**. To change your previous attestation, use the *PEBB Premium Surcharge Attestation Change Form*.

### Tobacco use premium surcharge

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

☐ **YES, I am subject to the $25 premium surcharge.** My spouse or partner has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the date their tobacco use changed.
**Date of change (mm/dd/yyyy)**
/ /

☐ **NO, I am not subject to the $25 premium surcharge.** My spouse or partner has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*. The surcharge also does not apply if you are a PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

## PEBB COVID-19 Enrollment/Change Form

Subscriber's last name

Subscriber's Social Security number

## Section 3 Medical plan selection

Only complete this section if you are enrolling in medical coverage or adding a new dependent to your medical coverage. You cannot change your or your current dependents' medical plan during this limited open enrollment.

Check only one plan listed below. Contact the plans for benefits information (see their information below).

**Kaiser Foundation Health Plan of the Northwest**[1]

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2,5]
- ☐ Kaiser Permanente NW Senior Advantage[3]
  (This plan is not available to employees.)

**Kaiser Foundation Health Plan of Washington**[1]

- ☐ Kaiser Permanente WA Classic [7]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA SoundChoice[6,7]
- ☐ Kaiser Permanente WA Value[7]
- ☐ Kaiser Permanente WA Medicare Plan[3, 4]
  (This plan is not available to employees.)

☐ **Premera Blue Cross Medicare Supplement Plan G**[8]
(This plan is not available to employees)

**Uniform Medical Plan, administered by Regence BlueShield**

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

Contact the plans for benefit and provider information. Their contact information is located below.

1. These plans have a specific service area. If you move out of the service area, you must change your plan. Otherwise, you will have limited access to network providers and covered services. You must report your new address to your personel, payroll or benefits office and request a plan change **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
3. These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the *PEBB Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available. (See **hca.wa.gov/erb** for medical plans available by county.)
4. If you cover dependents not enrolled in Medicare Part A and Part B, you must also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.
5. These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate your dependent's PEBB insurance coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.
6. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before you visit.
7. This plan is available only if at least one covered member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA Medicare Plan.
8. Also submit the *Group Medicare Supplement Enrollment Application* (form B) to enroll in Medicare Supplement Plan G.

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

**2020 PEBB Program medical contractors**

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

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

**Premera Blue Cross**
7001 220th St SW
Mountlake Terrace, WA 98043
1-800-807-7310 or TTY: 1-800-842-5357

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

## PEBB COVID-19 Enrollment/Change Form

Subscriber's last name

Subscriber's Social Security number

– –

## Section 4 Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If adding a state-registered domestic partner 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 PEBB verifies the dependent's eligibility. I understand that 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.

I allow my employer to deduct money from my earnings to pay for insurance coverage and any applicable premium surcharges.

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 my employer will contribute or the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf 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.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected. Benefit election changes made using this enrollment form replace all prior elections for similar benefits.

**Please sign and date.**

Subscriber's signature

Date / /

**Forms and documentation must be received by July 31, 2020.**

**Employees:** Return form and documentation to your personnel, payroll or benefits office.

**PEBB Continuation Coverage subscribers, return form and documentation to:**
Washington State Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684
**or fax to:** 360-725-0771.

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

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, employees should contact thier personnel, payroll or benefits office. PEBB Continuation Coverage subscribers should contact the PEBB Program.

Subscriber's last name

Subscriber's Social Security number

## Section 6 Dependent information

- List eligible dependents you wish to cover on your medical coverage, including children as defined in WAC 182-12-260(3). Use additional forms for more dependents. Dependents cannot be enrolled in two PEBB medical accounts at the same time.
- All PEBB employees (and PEBB Continuation Coverage subscribers enrolling a state-registered domestic partner) must provide proof of each dependent's eligibility no later than July 31, 2020, or the dependent will not be enrolled. All forms and a list of documents we will accept to verify dependent eligibility are available at **hca.wa.gov/erb**.
- If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).
- If enrolling an extended dependent, also attach a *PEBB Extended Dependent Certification* form.
- If enrolling a dependent child with a disability age 26 or older, also attach a *PEBB Certification of a Child With a Disability* form and return as instructed on the form. Refer to the *PEBB Employee Enrollment Guide* for eligibility information.

Relationship to subscriber

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

Last name Suffix

First name Middle initial Date of birth (mm/dd/yyyy)

Social Security number Sex ☐ M ☐ F

Street address

Address line 2

City State ZIP Code

**If you are enrolled in PEBB Continuation Coverage (COBRA), complete the information below. If you are an employee, skip ahead to the "Tobacco use premium surcharge" section.**

Covered by another group medical plan? ☐ Yes ☐ No If yes, effective date:

Covered by another group dental plan? ☐ Yes ☐ No If yes, effective date:

Disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date:

Disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date:

If yes, you must send a copy of your dependent's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

## PEBB COVID-19 Enrollment/Change Form

Subscriber's last name

Subscriber's Social Security number

Enrolled in Medicare Part A (hospital)? ☐ Yes ☐ No If yes, effective date: / /

Enrolled in Medicare Part B (medical)? ☐ Yes ☐ No If yes, effective date: / /

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

### Tobacco use premium surcharge

Does the tobacco use premium surcharge apply to your dependent? (Response required for dependents age 13 and older.) Check one.

☐ **Yes, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the date their tobacco use changed.
**Date of change (mm/dd/yyyy)**
/ /

☐ **No, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*. The surcharge does not apply if you are a PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

Subscriber's last name

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## Section 6 Dependent information

- List eligible dependents you wish to cover on your medical coverage, including children as defined in WAC 182-12-260(3). Use additional forms for more dependents. Dependents cannot be enrolled in two PEBB medical accounts at the same time.
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- If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).
- If enrolling an extended dependent, also attach a *PEBB Extended Dependent Certification* form.
- If enrolling a dependent child with a disability age 26 or older, also attach a *PEBB Certification of a Child With a Disability* form and return as instructed on the form. Refer to the *PEBB Employee Enrollment Guide* for eligibility information.

Relationship to subscriber

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

Last name Suffix

First name Middle initial Date of birth (mm/dd/yyyy)

Social Security number Sex ☐ M ☐ F

Street address

Address line 2

City State ZIP Code

**If you are enrolled in PEBB Continuation Coverage (COBRA), complete the information below. If you are an employee, skip ahead to the "Tobacco use premium surcharge" section.**

Covered by another group medical plan? ☐ Yes ☐ No If yes, effective date:

Covered by another group dental plan? ☐ Yes ☐ No If yes, effective date:

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Disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date:

If yes, you must send a copy of your dependent's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

## PEBB COVID-19 Enrollment/Change Form

Subscriber's last name

Subscriber's Social Security number

Enrolled in Medicare Part A (hospital)? ☐ Yes ☐ No If yes, effective date: / /

Enrolled in Medicare Part B (medical)? ☐ Yes ☐ No If yes, effective date: / /

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

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**Date of change (mm/dd/yyyy)**
/ /

☐ **No, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*. The surcharge does not apply if you are a PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

Subscriber's last name

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Relationship to subscriber

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Street address

Address line 2

City State ZIP Code

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Covered by another group medical plan? ☐ Yes ☐ No If yes, effective date:

Covered by another group dental plan? ☐ Yes ☐ No If yes, effective date:

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Disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date:

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## PEBB COVID-19 Enrollment/Change Form

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/ /

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