Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Temporary changes to SEBB Continuation Coverage deadlines

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

On April 2, 2020, the SEB Board passed resolutions to:

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

- **Extend the maximum continuation coverage period to the last day of the second month after the date the Governor ends the state of emergency.**
  - This means that you may have SEBB Continuation Coverage longer than is described in this document.
  - If your continuation coverage period would have ended between February 29 and the date that the state of emergency ends, your coverage will continue to the last day of the second month after the date the state of emergency ends. For example, if your coverage period would have ended April 30, and the state of emergency ends May 15, your coverage will be extended to July 31.
  - If your continuation coverage period would have **ended after the date the state of emergency ends, but before the two-month extension,** your coverage will continue to the last day of the second month after the date the state of emergency ends. For example, if the state of emergency ends May 15, and your continuation coverage ends June 30, your coverage will be extended to July 31.
  - If your continuation coverage period ends **on the last day of the two-month extension (or later)**, your coverage **will not** be extended. For example, if your coverage is set to end on October 31, and the state of emergency ends on May 15, your coverage will not be extended. It is already set to end more than two months after the end of the state of emergency.

Your first payment is due 45 days after the last day of your enrollment period, whether or not your enrollment period is extended. Learn more about these emergency resolutions at **hca.wa.gov/coronavirus.**

Clear form

2020 **SEBB Continuation Coverage (COBRA) Election/Change**

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Type or print clearly in black ink and use all capital, block lettering in the spaces provided. Example: J O H N Inaccurate, incomplete, or illegible information may delay coverage.

We must receive this form **no later than 60 days** from the date your SEBB health plan coverage ends or from the postmark date on the *SEBB Continuation Coverage Election Notice* packet sent to you, whichever is later. Submission directions are located after the signature on this form.

Your first premium payment and applicable premium surcharges (if any) are due to the Health Care Authority (HCA) no later than 45 days after your 60-day election period ends as described above. Premiums and applicable premium surcharges are due from the date your other coverage ended. If HCA does not receive your first premium payment and applicable premium surcharges during this timeframe, you will not be enrolled and you will lose your rights for SEBB Continuation Coverage (COBRA).

List eligible dependents you wish to enroll or remove from your coverage. This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted.

Remember to read and sign Section 7. To enroll and remove dependents, complete Section 8 on page 14.

! All forms and documents are available at **hca.wa.gov/erb** under *Forms & publications,* or by calling the SEBB Program at 1-800-200-1004 (TRS: 711) and selecting menu option 5.

1 Subscriber

Social Security number – – Date of birth (mm/dd/yyyy) / /

Last name

First name | Middle initial | Suffix | Sex (M/F)

Phone number – – Work phone number – – –

Residential address

Address line 2

City | State

ZIP/Postal Code | County

Country

(continued)

Subscriber Social Security number ___ – ___ – ____

Mailing address (if different from residential)

Mailing address line 2

City

State

ZIP/Postal Code

County

Country

You must report your new address to the SEBB Program **no later than 60 days** after you move, by using this form, calling 1-800-200-1004 (TRS: 711) and selecting menu option 5, or sending a written update to the address listed on page 11 of this form.

Are you or your dependent(s) already enrolled in SEBB insurance coverage under another account?

- ☐ **Yes**
- ☐ **No**

Continue coverage (select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Terminate coverage (select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

You may elect to continue coverage you were enrolled in on the day your SEBB health plan coverage ended. If you have life insurance and wish to port or convert, contact MetLife at 1-833-854-9624.

If you are enrolled in a Medical Flexible Spending Arrangement (FSA) and would like to continue it, contact Navia Benefit Solutions at 1-800-669-3539. Your request to continue enrollment must be received by Navia Benefit Solutions **no later than 60 days** from the date your SEBB health plan coverage ended or from the postmark date on Navia's COBRA election notice, whichever is later.

If you terminate coverage, you will not be eligible to reenroll in SEBB Continuation Coverage unless you regain eligibility for SEBB benefits as an employee.

If terminating coverage, include reason:_____

Termination date (mm/dd/yyyy) __ / __ / ____

Subscriber Social Security number ___ – ___ – ____

Are you covered by another group medical plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Are you covered by another group dental plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Are you covered by another group vision plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Are you disabled under Title II (OASDI) of the Social Security Act?

☐ Yes Effective date: (mm/dd/yyyy) __ / __ / ____

☐ No

Are you disabled under Title XVI (SSI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

! If you answered **Yes** to the Title II or Title XVI questions, include a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Are you enrolled in Medicare Part(s) A and/or B?
Part A (hospital)

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Part B (medical)

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

! If you answered **Yes,** proof is required. Include a copy of your Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy.

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

Tobacco Use Premium Surcharge

Response required for subscribers enrolling in medical coverage.

If you or a dependent (age 13 or older) enrolled on your SEBB medical coverage uses a tobacco product, you will be charged a monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in SEBB Program Administrative Policy 91-1 at **hca.wa.gov/sebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged this surcharge. For instructions on how to respond, see the *2020 SEBB Premium Surcharge Attestation Help Sheet* in the enrollment guide or at **hca.wa.gov/sebb-employee** under *Forms & publications*. To change your attestation, use the online enrollment system (SEBB My Account) or the *2020 Premium Surcharge Attestation Change* form.

Does the tobacco use premium surcharge apply to you?

☐ **Yes**, I am a non-Medicare subscriber and I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.

☐ **No**, I am a non-Medicare subscriber and 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 the tobacco cessation resources noted in the *2020 Premium Surcharge Attestation Help Sheet*.

☐ **No**, I am not subject to the $25 premium surcharge. I am a Medicare subscriber enrolled in Medicare Part A and Part B.

Subscriber Social Security number ___ – ___ – ____

2 Spouse/state-registered domestic partner

List an eligible spouse or state-registered domestic partner, as defined by WAC 182-31-140, you wish to enroll or remove from coverage. The section for dependent children starts on page 14. Dependents cannot be enrolled in two SEBB Program medical, dental, and vision accounts at the same time. You must provide proof of dependent eligibility within SEBB Program enrollment timelines, or they will not be enrolled. A list of acceptable documents to verify your dependent's eligibility is available at **hca.wa.gov/erb**.

Relationship to subscriber. Check one.

- ☐ Spouse: date of marriage: (mm/dd/yyyy) __ / __ / ____
- ☐ State-registered domestic partner: date registered (mm/dd/yyyy) __ / __ / ____

Social Security number ___ – ___ – ____

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

Last name

First name

Middle initial

Suffix

Sex (M/F)

Phone number ___ – ___ – ____

Work phone number ___ – ___ – ____

Residential address (if different from subscriber)

Address line 2

City

State

ZIP/Postal Code

County

Country

Continue coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Add coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Terminate coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Termination date (mm/dd/yyyy) __ / __ / ____

If terminating coverage, include reason:_____

! If removing a spouse or state-registered domestic partner due to a divorce or dissolution of state-registered domestic partnership, include a copy of the divorce decree or dissolution of state-registered domestic partnership.

Subscriber Social Security number ___ – ___ – ____

Is this person covered by another group medical plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

Is this person covered by another group dental plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

Is this person covered by another group vision plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

Is this person disabled under Title II (OASDI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

Is this person disabled under Title XVI (SSI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

If you answered **Yes** to either Title II or Title XVI, include a copy of your spouse's or state-registered domestic partner's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part(s) A and/or B?

Part A (hospital)

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

Part B (medical)

☐ **Yes** Effective date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ **No**

If you answered **Yes** to either Part A or Part B, proof is required. Include a copy of your spouse's or state-registered domestic partner's Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy.

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

Tobacco Use Premium Surcharge

Response required if enrolling your spouse or state-registered domestic partner in medical coverage.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in SEBB Program Administrative Policy 91-1 at **hca.wa.gov/sebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner?

☐ **Yes**, I am subject to the $25 premium 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 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or they have enrolled in the tobacco cessation resources noted in the *2020 SEBB Premium Surcharge Attestation Help Sheet*.

☐ **No,** I am not subject to the $25 premium surcharge. I am a Medicare subscriber.

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

Response required if enrolling your spouse or state-registered domestic partner in medical coverage.

You will be charged a monthly $50 premium surcharge in addition to your monthly medical premium if you enroll your spouse or state-registered domestic partner in SEBB medical coverage, and they have elected not to enroll in other employer-based group medical coverage that is comparable to the Public Employees Benefits Board (PEBB) Program Uniform Medical Plan (UMP) Classic plan. See the *2020 SEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond.

Does the spouse or state-registered domestic partner coverage surcharge apply to you?

☐ **Yes**, I am subject to the $50 premium surcharge. I used the *2020 SEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 SEBB Spousal Plan Calculator*.

If you check **Yes** or do not check any boxes below, you will be charged the monthly $50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium.

☐ **No**, I am not subject to the $50 premium surcharge. I used the *2020 SEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *2020 SEBB Spousal Plan Calculator*. Which questions, if any, on the *2020 SEBB Premium Surcharge Attestation Help Sheet* did you check **No**? Check all that apply.

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

☐ **Employer to determine if premium surcharge applies.** I used the *2020 SEBB Premium Surcharge Attestation Help Sheet* and am completing and submitting a printed *2020 SEBB Spousal Plan Calculator*. My employer will use these to determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to the PEBB UMP Classic plan and whether I am subject to this premium surcharge.

! The *2020 SEBB Premium Surcharge Attestation Help Sheet* and *2020 SEBB Spousal Plan Calculator* are available at **hca.wa.gov/erb** under *Forms & publications*.

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

3 Changes to an existing account

Are you making changes to an existing account?

☐ Yes

☐ No ! Continue to Section 4.

Changes you can make anytime

Date of event/change (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ Name change

☐ Address change

☐ Terminate medical coverage

☐ Terminate dental coverage

☐ Terminate vision coverage

☐ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, etc.). The SEBB Program must receive this form **no later than 60 days** after the date the dependent no longer meets SEBB eligibility criteria. Coverage will be terminated the last day of the month of loss of eligibility. If applicable, provide former dependent's new address:

Residential address

Address line 2

City State

ZIP/Postal Code

Additional changes you can make during the annual open enrollment

All changes become effective January 1 of the following year.

☐ **Add dependent(s)**

☐ **Change medical plan**

☐ **Change dental plan**

☐ **Change vision plan**

Changes you can make if an event creates a special open enrollment

The SEBB Program only allows changes outside of the annual open enrollment when an event creates a special open enrollment. The SEBB Program must receive this form and proof of the event **no later than 60 days** after the event occurs. To enroll a newborn or child whom you, the subscriber, has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, you should notify the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

Subscriber Social Security number ___ – ___ – ____

Date of event/change (mm/dd/yyyy) __ / __ / ____

A. Add dependent(s), change medical, dental, or vision plan:

- ☐ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form available at **hca.wa.gov/erb**.
- ☐ Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act.
- ☐ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution under their employer-based group health plan.
- ☐ Subscriber's dependent has a change in their own employment status that affects the dependent's eligibility for their employer contribution under their employer-based group health plan.
- ☐ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ☐ Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ Subscriber or dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.

B. Add dependent(s):

- ☐ Subscriber or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment.
- ☐ Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States, and that change in residence results in the dependent losing their health insurance.

C. Change medical, dental, or vision plan:

- ☐ Subscriber or dependent has a change in residence that affects health plan availability.
- ☐ Subscriber or dependent becomes entitled to or loses eligibility for Medicare.
- ☐ Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- ☐ Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program).
- ☐ Subscriber has a change in employment from a SEBB organization to a school district that crosses county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available.

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

4 Medical plan selection

Call the medical plan(s) you are interested in to make sure your provider is in the network. Contact the plans for benefits information. (Contact information is on page 12 of this form.) These plans have specific service areas based on your county of residence. See **hca.wa.gov/erb** for plans available to you.

If you move out of the medical plan's service area, you may need to change plans. You must report your new address to the SEBB Program **no later than 60 days** after you move using this form, by calling 1-800-200-1004 (TRS: 711), or by sending a written update to the address listed on page 11.

Choose one medical plan in this section.

- ☐ Kaiser Permanente NW 1
- ☐ Kaiser Permanente NW 2
- ☐ Kaiser Permanente NW 3
- ☐ Kaiser Permanente WA Core 1
- ☐ Kaiser Permanente WA Core 2
- ☐ Kaiser Permanente WA Core 3
- ☐ Kaiser Permanente WA SoundChoice[1]
- ☐ Kaiser Permanente WA Options Access PPO 1
- ☐ Kaiser Permanente WA Options Access PPO 2
- ☐ Kaiser Permanente WA Options Access PPO 3
- ☐ Premera High PPO
- ☐ Premera Peak Care EPO
- ☐ Premera Standard PPO
- ☐ UMP Achieve 1[2]
- ☐ UMP Achieve 2[2]
- ☐ UMP High Deductible [2]
- ☐ UMP Plus–Puget Sound High Value Network[2]
- ☐ UMP Plus–UW Medicine Accountable Care Network[2]

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

[2] Administered by Regence BlueShield

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

5 Dental plan selection

Choose one dental plan in this section. Before you enroll, make sure that the provider you want to use accepts the specific plan and group you choose.

Preferred Provider Organization (PPO)

☐ **Uniform Dental Plan,** (Group #09600) administered by Delta Dental of Washington

Managed-care plans

☐ **DeltaCare,** (Group #09601) administered by Delta Dental of Washington. 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 make sure that the provider you want to use accepts this plan.

☐ **Willamette Dental of Washington, Inc.,** (Group #WA 733) administered by Willamette Dental Group. You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call Willamette Dental at 1-855-433-6825 to make sure that the provider you want to use accepts this plan.

6 Vision plan selection

Choose one vision plan in this section. Before you enroll, make sure that the provider you want to use accepts the specific plan you choose.

☐ **Davis Vision**

☐ **EyeMed Vision Care**

☐ **MetLife Vision**

! Carrier contact information is on page 12.

Subscriber Social Security number ___ – ___ – ____

7 Signature

I have received and read the *SEBB Continuation Coverage Election Notice*, including any appendices. I declare that, by submitting this form, the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timeline in the SEBB 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 SEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the SEBB Program 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 I send payment, this does not mean that I will be automatically enrolled in SEBB insurance coverage. The SEBB Program will verify eligibility for me and my dependents. If we do not qualify, I will receive a refund.

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 medical premium.

If I enroll in a high-deductible health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the SEBB 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 me abiding by all applicable deadlines and SEBB rules and policies. Failure to comply with applicable deadlines and SEBB rules and policies may result in my benefits selection being rejected.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted to the SEBB Program.

Subscriber's signature

Date (mm/dd/yyyy)
__ / __ / ____

Mail form and applicable documents to:
Washington State Health Care Authority
PO Box 42684
Olympia, WA 98504-2684

If payment is enclosed, make check payable to Health Care Authority and mail, with form and applicable documents, to:
Washington State Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Or hand-deliver to:
Washington State Health Care Authority
626 8th Ave. SE
Olympia, WA 98501

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

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, call the SEBB Program at 1-800-200-1004 (TRS: 711).

! Continue to Section 8 to add or remove dependents.

2020 **SEBB Program contractors**

Do not send forms to the addresses below. This information is only for your reference.

Medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101-1374
1-888-901-4636
TTY: 1-800-833-6388 or 711

Kaiser Foundation Health Plan of Washington Options, Inc.
601 Union St., Suite 3100
Seattle, WA 98101
1-888-901-4636
TTY: 1-800-833-6388 or 711

Premera Blue Cross
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357 or 711

Uniform Medical Plan, administered by Regence BlueShield (for medical benefit questions)
1800 9th Ave.
Seattle, WA 98101
1-800-628-3481
TRS: 711

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

Dental contractors

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-537-3406
TTY: 800-833-6384

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-433-6825
TRS: 711

Vision contractors

Davis Vision
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
1-877-377-9353
TTY: 1-800-523-2847

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
1-800-699-0993
TTY: 1-844-230-6498

Metropolitan Life Insurance Company Vision Plan
PO Box 385018
Birmingham, AL 35238-5018
1-855-638-3931
TTY: 1-800-428-4833

Subscriber Social Security number ___ – ___ – ____

8 Dependents

Use this form to enroll or remove dependents such as a child defined by WAC 182-31-140. Use additional forms for more dependents. Dependents cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time.

If enrolling an extended dependent, attach an *Extended Dependent Certification* form, a valid court order showing legal custody or guardianship, and a *Declaration of Tax Status* form. If enrolling a non-qualified tax dependent, attach a *Declaration of Tax Status* form. If enrolling a dependent with a disability age 26 or older, submit a completed *Certification of Child With a Disability* form and return as instructed on the form.

Relationship to subscriber

- ☐ Child
- ☐ Stepchild (not legally adopted)
- ☐ Extended dependent (court order needed)
- ☐ Disabled dependent (age 26 or older)

! If adding more than two dependents, copy pages 16-17 and attach to form.

Social Security number ___ – ___ – ____ Date of birth (mm/dd/yyyy) __ / __ / ____

Last name

First name Middle initial Suffix Sex (M/F)

Phone number ___ – ___ – ____ Work phone number ___ – ___ – ____

Residential address (if different from subscriber)

Address line 2

City State

ZIP/Postal Code County

Country

Continue coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Add coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Terminate coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Termination date (mm/dd/yyyy) __ / __ / ____

If terminating coverage, include reason:_____

Subscriber Social Security number ___ – ___ – ____

Is this person covered by another group medical plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Is this person covered by another group dental plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Is this person covered by another group vision plan?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Is this person disabled under Title II (OASDI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Is this person disabled under Title XVI (SSI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

! If you answered **Yes** to either Title II or Title XVI, include a copy of your dependent's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part(s) A and/or B?

Part A (hospital)

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

Part B (medical)

☐ **Yes** Effective date (mm/dd/yyyy) __ / __ / ____

☐ **No**

! If you answered **Yes** to either Part A or Part B, proof is required. Include a copy of your dependent's Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge

Response required if enrolling your dependent in medical coverage.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in SEBB Program Administrative Policy 91-1 at **hca.wa.gov/sebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the tobacco use premium surcharge apply to your dependent?

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

☐ **No,** I am not subject to the $25 premium surcharge. My 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 SEBB Premium Surcharge Attestation Help Sheet*.

☐ **No**, I am not subject to the $25 premium surcharge. I am a Medicare subscriber enrolled in Medicare Part A and Part B.

Subscriber Social Security number ___ – ___ – ____

8 Dependents

Use this form to enroll or remove dependents such as a child defined by WAC 182-31-140. Use additional forms for more dependents. Dependents cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time.

If enrolling an extended dependent, attach an *Extended Dependent Certification* form, a valid court order showing legal custody or guardianship, and a *Declaration of Tax Status* form. If enrolling a non-qualified tax dependent, attach a *Declaration of Tax Status* form. If enrolling a dependent with a disability age 26 or older, submit a completed *Certification of Child With a Disability* form and return as instructed on the form.

Relationship to subscriber

- ☐ Child
- ☐ Stepchild (not legally adopted)
- ☐ Extended dependent (court order needed)
- ☐ Disabled dependent (age 26 or older)

! If adding more than two dependents, copy pages 16-17 and attach to form.

Social Security number ___ – ___ – ____ Date of birth (mm/dd/yyyy) __ / __ / ____

Last name

First name Middle initial Suffix Sex (M/F)

Phone number ___ – ___ – ____ Work phone number ___ – ___ – ____

Residential address (if different from subscriber)

Address line 2

City State

ZIP/Postal Code County

Country

Continue coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Add coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Terminate coverage
(select all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Vision

Termination date (mm/dd/yyyy) __ / __ / ____

If terminating coverage, include reason:_____

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

Is this person covered by another group medical plan?

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

Is this person covered by another group dental plan?

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

Is this person covered by another group vision plan?

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

Is this person disabled under Title II (OASDI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

Is this person disabled under Title XVI (SSI) of the Social Security Act?

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

! If you answered **Yes** to either Title II or Title XVI, include a copy of your dependent's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part(s) A and/or B?

Part A (hospital)

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

Part B (medical)

☐ **Yes** Effective date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No**

! If you answered **Yes** to either Part A or Part B, proof is required. Include a copy of dependent's Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge

Response required if enrolling your dependent in medical coverage.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in SEBB Program Administrative Policy 91-1 at **hca.wa.gov/sebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

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☐ **No,** I am not subject to the $25 premium surcharge. My 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 SEBB Premium Surcharge Attestation Help Sheet*.

☐ **No**, I am not subject to the $25 premium surcharge. I am a Medicare subscriber enrolled in Medicare Part A and Part B.