Clear Form

SEBB COVID-19 Enrollment/Change Form

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Only for use from July 1 through 31, 2020

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

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 7.
Example: J O H N

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

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

! Remember to sign and date page 7. To add dependents, fill out Section 6 starting on page 9.

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 ___ - ___ - ____

Street address

Address line 2

City State

ZIP/Postal Code County

Country

! If your address changes, you must give your new address to your payroll or benefits office no later than 60 days after you move.

Mailing address (if different from above)

Mailing address line 2

City State

ZIP/Postal Code Country

Subscriber Social Security number ___ – ___ – ____

If you are enrolled in SEBB Continuation Coverage (COBRA), complete the information below. If you are a school 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 ___ / ___ / ____

Covered by another group vision 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 Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part A? ☐ Yes ☐ No If yes, effective date ___ / ___ / ____

Enrolled in Medicare Part B? ☐ 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 SEBB 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 *SEBB 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 monthly $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.
(mm/dd/yyyy) ___ / ___ / ____

☐ **No, I am not subject to the monthly $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 *SEBB Premium Surcharge Attestation Help Sheet*. The surcharge does not apply if you are a SEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

Subscriber Social Security number

2 Spouse/State-registered domestic partner

Skip this section if you are not enrolling a spouse or state-registered domestic partner, as defined by WAC 182-31-140.

List an eligible spouse or state-registered domestic partner you wish to add to your SEBB medical coverage.

All school employees (and SEBB 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 SEBB medical accounts at the same time.

Relationship to subscriber.

- Spouse: date of marriage (mm/dd/yyyy):
- State-registered domestic partner: date registered (mm/dd/yyyy):
  If adding a state-registered domestic partner, please attach a *SEBB 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).

Social Security number

Date of birth (mm/dd/yyyy)

Last name

First name

Middle initial

Suffix

Sex (M/F)

Phone number

Work phone number

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal Code

County

Country

Subscriber Social Security number ___ – ___ – ____

If you are enrolled in SEBB Continuation Coverage (COBRA), complete the information below. If you are a school employee, skip ahead to the next page.

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

Covered by another group dental plan? ☐ Yes ☐ No If yes, effective date __ / __ / ____

Covered by another group vision plan? ☐ Yes ☐ No If yes, effective date __ / __ / ____

Disabled under Title II (OASDI) 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.

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

Enrolled in Medicare Part A? ☐ Yes ☐ No If yes, effective date __ / __ / ____

Enrolled in Medicare Part B? ☐ 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.

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

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 $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) Uniform Medical Plan (UMP) Classic plan. See the *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? Check one:

☐ **Yes, I am subject to the $50 premium surcharge.** I used the *SEBB Premium Surcharge Attestation Help Sheet* and completed the *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 *SEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *SEBB Spousal Plan Calculator*. The surcharge does not apply if you are a SEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.
If NO, which questions on the *SEBB 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 school employees) or the SEBB Program (for SEBB Continuation Coverage subscribers) to determine if premium surcharge applies. I used the *SEBB Premium Surcharge Attestation Help Sheet* and am completing and submitting a printed *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.

Tobacco use premium surcharge
Response required if enrolling your spouse or state-registered domestic partner in medical coverage. 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 you? Check one:

☐ **Yes, I am subject to the monthly $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. (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ **No, I am not subject to the monthly $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 *SEBB Premium Surcharge Attestation Help Sheet*. The surcharge does not apply if you are a SEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

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

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 plans during this limited open enrollment. Check only one plan listed below. Contact the plans for benefits information (see their contact information on page 10.)

- ☐ 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]

Information about medical plan options can be found at **hca.wa.gov/erb** and in the enrollment guide. Contact the plans for benefits information. (Contact information is on page 8 of this form.) Before you enroll, make sure that the provider you want to use accepts the specific plan you choose.

These plans have specific service areas. All school employees are offered a selection of plans based on their county of residence. Some school employees, including employees who live outside Washington State, may have more plan options if they work in a district that crosses county lines or is in a county that borders Idaho or Oregon.

If you move out of the medical plan's service area or change jobs to a different district, charter school, or educational service district (represented employees only), you may need to change plans. You must report your new address and any request to change your health plan to your payroll or benefits office no later than 60 days after your move.

[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 ___ – ___ – ____

4 Signature

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 timelines 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 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, denial of insurance benefits, and loss of my job.
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 of any dependent is not complete until the SEBB Program verifies the eligibility of my dependents. I understand that if I am applying to add a dependent to my SEBB insurance coverage, I must provide copies of documents that verify the dependent's eligibility within the SEBB 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. 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 enroll in a high-deductible health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute or 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. Benefit election changes made using this enrollment form replace all prior elections for similar benefits.

Please sign and date.
Subscriber's signature

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

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

School employees: Return form and documentation to your payroll or benefits office.
SEBB Continuation Coverage subscribers: Return form and documentation to: Washington State Health Care Authority, SEBB Program, PO 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 an accommodation, or require documents in another format, employees should contact their payroll or benefits office. SEBB Continuation Coverage subscribers should contact the SEBB Program.

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

Subscriber Social Security number ___ - ___ - ____

5 **This section to be completed by a school district, charter school, or educational service district benefits administrator**

HCA Code

Organization number

Organization name

Type of organization

- ☐ School district
- ☐ Charter school
- ☐ Educational service district

Eligibility: Check one

- ☐ Subscriber is **SEBB-eligible**
- ☐ Subscriber is **locally eligible**

Effective date (mm/dd/yyyy)
08 / 01 / 2020

2020 SEBB Program contractors

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

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
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

Uniform Medical Plan
administered by Regence BlueShield (for medical benefit questions)
1800 Ninth Avenue, Suite 235
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)

Subscriber Social Security number ___ – ___ – ____

6 Dependent information

List eligible dependents you wish to add to your SEBB medical coverage, including children as defined in WAC 182-31-140(3). Use additional forms for more dependents.

All school employees (and SEBB 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.

If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *SEBB 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, attach a *SEBB Extended Dependent Certification* form, a valid court order showing legal custody or guardianship, and a *SEBB Declaration of Tax Status* form. If enrolling a non-qualified tax dependent, attach a *SEBB Declaration of Tax Status* form.

If enrolling a dependent child with a disability age 26 or older, also attach a *SEBB Certification of a Child With a Disability* form, unless you meet an exception outlined in the School Employee Enrollment Guide. All forms and a list of documents we will accept to verify dependent eligibility are available at **hca.wa.gov/erb**.

Relationship to subscriber

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

! Dependents cannot be enrolled in two SEBB medical accounts. Refer to the enrollment guide or **hca.wa.gov/erb** for information and a list of verification documents.

Social Security number ___ – ___ – ____

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

Last name

First name

Middle initial

Suffix

Birth sex (M/F)

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal Code

County

Country

Subscriber Social Security number ___ – ___ – ____

If you are enrolled in SEBB Continuation Coverage (COBRA), complete the information below. If you are a school 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 __ / __ / ____

Covered by another group vision 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.

Enrolled in Medicare Part A? ☐ Yes ☐ No If yes, effective date __ / __ / ____

Enrolled in Medicare Part B? ☐ 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 this dependent? (Response required for dependents age 13 and older) Check one:

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

☐ **No, I am not subject to the monthly $25 premium surcharge**. My dependent 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 *SEBB Premium Surcharge Attestation Help Sheet*. The surcharge does not apply if you are a SEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

Subscriber Social Security number ___ – ___ – ____

6 Dependent information

List eligible dependents you wish to add to your SEBB medical coverage, including children as defined in WAC 182-31-140(3). Use additional forms for more dependents.

All school employees (and SEBB 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.

If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *SEBB 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, attach a *SEBB Extended Dependent Certification* form, a valid court order showing legal custody or guardianship, and a *SEBB Declaration of Tax Status* form. If enrolling a non-qualified tax dependent, attach a *SEBB Declaration of Tax Status* form.

If enrolling a dependent child with a disability age 26 or older, also attach a *SEBB Certification of a Child With a Disability* form, unless you meet an exception outlined in the School Employee Enrollment Guide. All forms and a list of documents we will accept to verify dependent eligibility are available at **hca.wa.gov/erb**.

Relationship to subscriber

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

! Dependents cannot be enrolled in two SEBB medical accounts. Refer to the enrollment guide or **hca.wa.gov/erb** for information and a list of verification documents.

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

Last name

First name Middle initial Suffix Birth sex (M/F)

Street address (if different from subscriber)

Address line 2

City State

ZIP/Postal Code County

Country

! Use additional forms to list more dependents.

Subscriber Social Security number ___ – ___ – ____

If you are enrolled in SEBB Continuation Coverage (COBRA), complete the information below. If you are a school 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 __/__/____

Covered by another group vision 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.

Enrolled in Medicare Part A? ☐ Yes ☐ No If yes, effective date __/__/____

Enrolled in Medicare Part B? ☐ 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 this dependent? (Response required for dependents age 13 and older) Check one:

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

☐ **No, I am not subject to the monthly $25 premium surcharge**. My dependent 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 *SEBB Premium Surcharge Attestation Help Sheet*. The surcharge does not apply if you are a SEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B.

 Use additional forms to list more dependents.