Clear form

2020 **Premium Payment Plan Election/Change**

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

You may use this form:

- When you are newly eligible for SEBB benefits and wish to opt out of the premium payment plan (complete Section 3.)
- During the SEBB Program's annual open enrollment.
- After an event that creates a special open enrollment (for example, a change in employment status, marriage, birth, adoption, etc.).

The change must correspond to and be consistent with the event that creates the special open enrollment.

For more information about changes you can make during a special open enrollment, read WAC 182-30-100(3)(a) at **hca.wa.gov/sebb-rules.**

Please type or print clearly in blue or black ink in the spaces provided. Example: J O H N

1 Subscriber (school employee) information

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

Last name

First name Middle initial Suffix

Is this a name change?

☐ Yes ☐ No

Phone number ___ – ___ – ____ Alternate phone number ___ – ___ – ____

Residential address

Address line 2

City

County State ZIP/Postal Code

Mailing address (if different than residential)

Address line 2

City State

ZIP/Postal Code

Subscriber Social Security number

2 Participation in Premium Payment Plan

Check one.

☐ I elect to opt out of participation in the state of Washington's Premium Payment Plan. I understand that any premium I am required to pay for my SEBB medical coverage, and any applicable premium surcharges, will be deducted from my paycheck after federal and/or state taxes have been collected.

☐ I elect to enroll in the state of Washington's Premium Payment Plan. I understand that by participating in the Premium Payment Plan, any premium I am required to pay for my SEBB medical coverage, and any applicable premium surcharges, will be deducted from my paycheck before federal and/or state taxes have been collected.

Employee signature

Date (mm/dd/yyyy)

! Return original form to your payroll or benefits office. Keep a copy for your records.

3 SEBB organization information

HCA code

School employee's hire date (mm/dd/yyyy)

Effective date of change (mm/dd/yyyy)

! Payroll or benefits office completes this section.