Clear form

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

# 2023 School Employee Enrollment Form

**Please use this form only if you are unable to use the online enrollment system, SEBB My Account.**

The information written on this form replaces all enrollment forms previously submitted. Therefore, you must complete the entire form, including the dependent section for any children you wish to continue to cover. Inaccurate, incomplete, or illegible information may delay coverage.

To make changes during annual open enrollment or a special open enrollment, go to SEBB My Account or submit a *School Employee Change Form* to your payroll or benefits office.

Benefits differ for employees whose eligibility was locally negotiated under WAC 182-30-130(6). See *Am I eligible?* on HCA's website at **hca.wa.gov/sebb-employee** for details.

All members who are eligible for both the SEBB Program and Public Employees Benefits Board (PEBB) Program are limited to enrolling in health plans through either the SEBB Program or the PEBB Program. Subscribers must choose enrollment through one program or the other in medical, dental, and vision plans (SEBB Program) or medical and dental plans (PEBB Program). Choosing some SEBB plans and some PEBB plans is no longer allowed.

Type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example: J O H N

⚠ Remember to read and sign Section 6. To enroll children, complete Section 8 on page 9.

## 1 Subscriber

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit HCA's website at **hca.wa.gov/gender-x**.

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

## 2023 School Employee Enrollment Form

Subscriber's last name

Social Security number

Are you or your dependents enrolled in SEBB or PEBB insurance coverage under another account? ☐ Yes ☐ No

⚠ If yes, please contact your payroll or benefits office for help. All members are limited to enrolling in health plans through either the PEBB Program or the SEBB Program.

## Choose one box for each type of coverage.

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| ☐ Cover | ☐ Cover | ☐ Cover |
| ☐ Waive | ☐ Waive (Dental may only be waived if the subscriber enrolls in PEBB medical and PEBB dental.) | ☐ Waive (Vision may only be waived if the subscriber enrolls in PEBB medical and PEBB dental.) |

You can waive SEBB medical coverage if you are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. However, you must enroll in SEBB dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and, if applicable, employer-paid long-term disability (LTD) insurance. You will be enrolled in employee-paid LTD insurance unless you decline coverage. If you waive medical coverage for yourself, you cannot enroll your dependents in SEBB medical coverage.

## Tobacco use premium surcharge

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

For instructions on how to respond, see the *SEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/sebb-employee** under *Forms & publications*.

If you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge.

**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.

☐ **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 the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Social Security number

## 2 Spouse or State-registered domestic partner (SRDP)

List an eligible spouse or SRDP you wish to enroll in medical, dental, or vision coverage. State-registered domestic partner is defined in WAC 182-31-020. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. To enroll children, please complete Section 8, located at the end of the form.

You must provide proof of your spouse or SRDP's eligibility within the SEBB Program's timelines, or they will not be enrolled. Timelines and a list of acceptable documents to verify eligibility is available on HCA's website at **hca.wa.gov/sebb-employee**.

If your spouse or SRDP is eligible to enroll in both the PEBB and SEBB Programs, they are limited to enrolling in SEBB medical, dental, and vision or enrolling in PEBB medical and dental. If they are a SEBB employee who waives SEBB medical for PEBB medical, they must also enroll in PEBB dental coverage.

### Relationship to subscriber. Choose one.

☐ Spouse: Date of marriage: (mm/dd/yyyy)

☐ SRDP: Date registered: (mm/dd/yyyy)

⚠ If enrolling an SRDP, also submit a *SEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes.

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

### Choose one box for each type of coverage.

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| ☐ Add to coverage | ☐ Add to coverage | ☐ Add to coverage |
| ☐ Decline coverage | ☐ Decline coverage | ☐ Decline coverage |

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit HCA's website at **hca.wa.gov/gender-x**.

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Subscriber's last name

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### Tobacco use premium surcharge

Response required if enrolling your spouse or state-registered domestic partner (SRDP) in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See the *SEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/sebb-employee** 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. This person has used tobacco products in the past two months.
- **No**, I am not subject to the $25 premium surcharge. This person 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.

### Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The SEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in SEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan (UMP) Classic. See the *SEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond.

⚠ The *SEBB Premium Surcharge Attestation Help Sheet* and the *SEBB Spousal Plan Calculator* are available at **hca.wa.gov/sebb-employee** under *Surcharges*.

**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 *SEBB Premium Surcharge Attestation Help Sheet* and completed the *SEBB Spousal Plan Calculator*.

⚠ If you check Yes or do not check any boxes, you will be charged the $50 premium surcharge.

- **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*. Which questions on the *SEBB Premium Surcharge Attestation 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

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

Subscriber's last name

Social Security number

## 3 Medical plan selection

### Choose one medical plan.

**Kaiser Foundation Health Plan of the Northwest[1] (Kaiser Permanente NW)**

- ☐ Kaiser Permanente NW 1
- ☐ Kaiser Permanente NW 2
- ☐ Kaiser Permanente NW 3

**Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)**

- ☐ Kaiser Permanente WA Core 1
- ☐ Kaiser Permanente WA Core 2
- ☐ Kaiser Permanente WA Core 3
- ☐ Kaiser Permanente WA SoundChoice

**Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente WA Options)**

- ☐ Kaiser Permanente WA Options Summit PPO 1
- ☐ Kaiser Permanente WA Options Summit PPO 2
- ☐ Kaiser Permanente WA Options Summit PPO 3

**Premera Blue Cross**

- ☐ Premera High PPO
- ☐ Premera HMO
- ☐ Premera Standard PPO

**Uniform Medical Plan (UMP), administered by Regence BlueShield and Washington State Rx Services**

- ☐ UMP Achieve 1
- ☐ UMP Achieve 2
- ☐ UMP High Deductible
- ☐ UMP Plus–Puget Sound High Value Network
- ☐ UMP Plus–UW Medicine Accountable Care Network

⚠ Information about medical plan options can be found on HCA's website at **hca.wa.gov/sebb-employee**. Call the plans with questions about benefits and provider information. (Contact information is on page 8 of this form.) Before you enroll, call the plan to make sure the provider you want to use accepts the specific plan you choose.

If you are eligible for the employer contribution toward SEBB benefits, but do not waive or enroll in SEBB medical coverage, you will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Achieve 1, administered by Regence BlueShield, as your medical plan. Other automatic plan enrollment for employees who do not make elections includes Uniform Dental Plan, MetLife Vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and, if applicable, employer-paid long-term disability (LTD) insurance. Enrollment in employee-paid LTD insurance is automatic. However, you can choose a lower cost coverage level or decline the coverage. Your dependents will not be enrolled. You will be charged a monthly $42 premium for medical coverage as well as a $25 monthly tobacco use premium surcharge.

These plans have specific service areas. You must live or work in the medical plan's service area to join the plan. All school employees are offered a choice of plans based on their county of residence or the county where their school district, charter school, or educational service district is based. If you work in a district that crosses county lines, you will want to identify all counties in which your school district is located to see all plan options available to you. **Exceptions**: To enroll in a Kaiser Permanente plan, you must live or work in the service area at least 50 percent of the time; your residential, charter school, or ESD address or the school district you work for must be in Kaiser Permanente's service area. To enroll in a UMP Plus plan, you must live in the service area.

If you move out of the medical plan's service area or change jobs to a different district, charter school, or educational service district, you may need to change plans. Otherwise, you will have limited access to network providers and covered services. 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 Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

Subscriber's last name

Social Security number

## 4 Dental plan selection

Choose one dental plan in this section. Before you enroll, call the plan to make sure the provider you want to use accepts the specific plan and group you choose. If you do not select a dental plan you will be automatically enrolled in Uniform Dental Plan (Group #09600).

### Preferred Provider Organization (PPO)

☐ **Uniform Dental Plan** (Group #09600)
You can choose any dental provider and change providers at any time.

### Managed-care plans (limited network)

☐ **DeltaCare** (Group #09601)
You must select a primary care dentist in the DeltaCare network.

☐ **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 network.

## 5 Vision plan selection

Choose one vision plan in this section. Before you enroll, call the plan to make sure the provider you want to use accepts the specific plan you choose. If you do not choose a vision plan, you will be automatically enrolled in MetLife Vision.

☐ **Davis Vision**, underwritten by HM Life Insurance Company

☐ **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company

☐ **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

⚠ Carrier contact information is on page 8.

Subscriber's last name

Social Security number

## 6 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 the SEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans 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. 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 SEBB insurance benefits.

If adding a state-registered domestic partner (SRDP) 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.

Eligible employees must enroll in SEBB dental, vision, basic life, basic accidental death and dismemberment, and employer-paid long-term disability (LTD) insurance[1]. Employees will be enrolled in employee-paid LTD insurance unless they decline coverage. Employees that elect to waive SEBB medical coverage must be enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If I waive medical coverage, I understand I can enroll during the annual open enrollment period or **no later than 60 days** after a special open enrollment event as defined in the SEBB Program rules. If I waive medical coverage for myself, I cannot enroll my eligible dependents in medical coverage.

If I am eligible for the employer contribution toward SEBB benefits but do not waive or enroll in SEBB medical coverage, I will be enrolled automatically as a single subscriber in Uniform Medical Plan (UMP) Achieve 1. My dependents will not be enrolled. I will be charged a monthly $42 premium for medical coverage as well as a $25 monthly tobacco use premium surcharge. 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 applicable tobacco use premium surcharge and spouse or SRDP 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 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 or defaulted. This form replaces all enrollment forms previously submitted.

### Sign, date, and return form and documentation to your payroll or benefits office.

Subscriber's signature

Date

⚠ Continue to Section 8 to add children.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact your payroll or benefits office.

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

1 Not available to employees whose eligibility was locally negotiated under Washington Administrative Code (WAC) 182-30-130(6).

## 2023 School Employee Enrollment Form

Subscriber's last name

Social Security number

## 7 Employer

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

HCA Code

Organization number

Organization name

Organization name (continued)

**Type of organization**

- School district
- Charter school
- Educational service district

**Eligibility: Check one**

- Subscriber is SEBB-eligible
- Subscriber is locally eligible

Eligibility date

Effective date

## SEBB Program contractors

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

### Medical

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

**Kaiser Foundation Health Plan of Washington**
1300 SW 27th Street
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388 (TRS: 711)

**Kaiser Foundation Health Plan of Washington Options, Inc.**
1300 SW 27th Street
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388 (TRS: 711)

**Premera Blue Cross**
High PPO and Standard PPO
PO Box 327
Seattle, WA 98111
1-800-807-7310
TTY: 1-800-842-5357 (TRS: 711)

**Premera HMO**
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357 (TRS: 711)

**Uniform Medical Plan,** administered by Regence BlueShield (for medical benefit questions)
PO Box 2998
Tacoma, WA 98401
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

**DeltaCare**
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

**Uniform Dental Plan**
400 Fairview Ave. N., Suite 800
Seattle, WA 98109-5371
1-800-537-3460
TTY: 1-800-833-6384

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

### Vision

**Davis Vision Inc.**, underwritten by HM Life Insurance Company
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
1-877-377-9353
TTY: 1-800-523-2847

**EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
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
1-833-854-9624
TTY: 1-800-428-4833

Subscriber's last name

Social Security number

## 8 Dependents

List eligible dependents you wish to enroll. Enrolled children must be eligible under SEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability.

If enrolling a dependent, you must provide proof of their eligibility within the SEBB Program's enrollment timelines or the dependent will not be enrolled. Timelines and a list of documents we will accept to verify eligibility are available on HCA's website at **hca.wa.gov/sebb-employee**.

If adding a state-registered domestic partner's child, extended dependent, or other nonqualified tax dependent, also attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

If enrolling an extended dependent, attach a *SEBB Extended Dependent Certification.*

If enrolling a child with a disability (age 26 or older), submit a *SEBB Certification of a Child with a Disability* as instructed on the form.

**Relationship to subscriber**

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

**If your dependent is eligible to enroll in both the SEBB and PEBB Programs, they are limited to enrolling in SEBB medical, dental, or vision or enrolling in PEBB medical and dental. If they are a SEBB employee who waives SEBB medical for PEBB medical, they must also enroll in PEBB dental coverage.**

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit HCA's website at **hca.wa.gov/gender-x**.

## 2023 School Employee Enrollment Form

Subscriber's last name

Social Security number

### Choose one box for each type of coverage.

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| ☐ Add to coverage | ☐ Add to coverage | ☐ Add to coverage |
| ☐ Decline coverage | ☐ Decline coverage | ☐ Decline coverage |

### Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 and older in medical coverage.

If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See the *SEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/sebb-employee** 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. This person has used tobacco products in the past two months.

☐ **No**, I am not subject to the $25 premium surcharge. This person 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*.

⚠ **Use additional forms to list more dependents.**