Clear form

HCA | Health Care Authority
School Employees Benefits Board

2026 School Employee Enrollment/Change form

Use this form if you are unable to use Benefits 24/7 at **benefits247.hca.wa.gov**.

This form replaces all enrollment/change forms previously submitted. You must complete the entire form, including the dependent section for any children you want to continue to cover. Inaccurate, incomplete, or illegible information may delay coverage.

All members who are eligible for both the SEBB Program and the Public Employees Benefits Board (PEBB) Program must choose health plan enrollment through one program. Choosing some plans in both programs is not allowed.

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

⚠ Remember to read and sign Section 8.

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

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Subscriber's last name

Social Security number

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 you enroll in PEBB dental and vision.)	☐ Waive (Vision may only be waived if you enroll in PEBB dental and vision.)

⚠ If you waive medical coverage, you cannot enroll your dependents in medical. You can waive medical coverage if you are enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B.

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

⚠ If Yes, contact your payroll or benefits office for help.

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The SEBB Program requires a $25-per-account tobacco use 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. Refer to the *School Employee Enrollment Guide* or visit HCA's website at **hca.wa.gov/sebb-employee** for more information.

If you check Yes or leave this section blank, you will be charged the $25 premium surcharge. If this is a change to a previous attestation, submit the *SEBB Premium Surcharge Attestation Change Form*.

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 one of the tobacco cessation resources.

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

If enrolling or removing a spouse or SRDP, complete this section. If not, skip to the next section.

List your spouse or SRDP you wish to cover or remove from coverage. SRDP is defined in WAC 182-31-020. State-registered domestic partnerships include partners of legal unions from another jurisdiction that is substantially equivalent to a domestic partnership in Washington State. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law.

You must provide proof of their eligibility within the SEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of accepted documents are 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 a single enrollment in medical, dental, and vision plans from either the SEBB Program or the PEBB Program as described in WAC 182-31-070. They may not be enrolled in health plans in both programs.

Relationship to subscriber

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

☐ **SRDP (Washington State):** Partnership start date (mm/dd/yyyy)

☐ **SRDP (legal union):** Start date (mm/dd/yyyy)

⚠ If enrolling an SRDP, attach a *SEBB Declaration of Tax Status* 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

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
☐ Cover	☐ Cover	☐ Cover
☐ Remove from coverage	☐ Remove from coverage	☐ Remove from coverage

If removing from coverage, include reason:

1 This field is required for health care services.

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

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Tobacco use premium surcharge

Response required if enrolling your spouse or 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 page 2 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.

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 enroll your spouse or SRDP in SEBB medical and they have chosen not to enroll in another employer-based group medical insurance that is comparable to the PEBB Program's Uniform Medical Plan (UMP) Classic.

Answer these questions for your spouse or SRDP in 2026:

1. Are you covering your spouse or SRDP in a SEBB medical plan?
   ☐ Yes ☐ No
2. Will they be eligible for medical coverage through their employer? (If they will not be employed, answer No.)
   ☐ Yes ☐ No
3. Will their employer offer at least one medical plan that serves their county of residence?
   ☐ Yes ☐ No
4. Have they chosen not to enroll in their employer's medical coverage?
   ☐ Yes ☐ No
5. Will the coverage offered by their employer **not** be through the SEBB or PEBB Program or a TRICARE plan?
   Answer Yes if their employer **does not** offer SEBB or PEBB coverage or a TRICARE plan.
   Answer No if their employer **offers** SEBB or PEBB coverage or a TRICARE plan.
   ☐ Yes ☐ No
6. Will their share of the medical premium through their employer be less than $137.76 per month?
   ☐ Yes ☐ No

If you answered No to any of these questions, check No below. You will not be charged the surcharge.
If you answered Yes to all of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:
   a. Serve their county of residence.
   b. Have a monthly premium of less than $137.76 per month for the employee.
2. Use the SBC information to answer the questions in the *SEBB Spousal Plan Calculator* tool. You will get a Yes or No response from the calculator. Enter this response below.

⚠ The *SEBB Spousal Plan Calculator* is available at **hca.wa.gov/sebb-employee** under *Surcharges*.

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Subscriber's last name

Social Security number

Does the spouse or SRDP coverage surcharge apply to you? Check one:

- ☐ **Yes**, I am subject to the $50 premium surcharge. I completed the *SEBB Spousal Plan Calculator*.
- ☐ **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *SEBB Spousal Plan Calculator*.
- ☐ I need my employer to determine if the premium surcharge applies. I am submitting a printed *SEBB Spousal Plan Calculator*.

⚠ If you check Yes or leave this section blank, you will be charged the monthly $50 premium surcharge.

Subscriber's last name

Social Security number

3 Dependents

If enrolling or removing a dependent, complete this section. If not, skip to the next section.

List dependents you wish to add or remove from coverage. They 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) and children age 26 or older with a disability.

You must provide proof of their eligibility within the SEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of accepted documents are available on HCA's website at **hca.wa.gov/sebb-employee**.

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

If enrolling an extended dependent, submit 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.*

If they are eligible to enroll in both the SEBB and PEBB Programs, they are limited to a single enrollment in medical, and if applicable, dental and vision from either the SEBB Program or PEBB Program as described in WAC 182-31-070. They may not enroll in both programs.

⚠ **If adding more dependents, copy the dependents section and attach to this form.**

Relationship to subscriber

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

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

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

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Subscriber's last name

Social Security number

Choose one box for each type of coverage.

Medical coverage	Dental coverage	Vision coverage
☐ Cover	☐ Cover	☐ Cover
☐ Remove from coverage	☐ Remove from coverage	☐ Remove from coverage

If removing from coverage, include reason:

Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 or older in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium. See page 2 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 dependent has used tobacco products in the past two months.

☐ **No**, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources.

Subscriber's last name

Social Security number

4 Medical plan selection

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

Kaiser Foundation Health Plan of the Northwest (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 ArrayRx

- UMP Achieve 1
- UMP Achieve 2
- UMP High Deductible

⚠ If you are eligible for 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. Your dependents will not be enrolled. You will be charged a monthly 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 employment location is based. If you work in a district that crosses county lines, identify all counties your school district is in to see all plan options available.

If you move out of the service area or change jobs to a different employment location and your current medical plan is no longer available, you must select a new plan. If you do not, the SEBB Program will enroll you in a plan. 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.

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

5 Dental plan selection

Choose one dental plan. 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), administered by Delta Dental of Washington
  You can choose any dental provider and change providers at any time. Your out-of-pocket costs will be lower if you use a preferred provider.

Managed-care plans (limited network)

- **DeltaCare** (Group #09601), administered by Delta Dental of Washington.
  You must select a primary care dentist in the DeltaCare network.
- **Willamette Dental of Washington, Inc.** (Group WA 733), administered by Willamette Dental of Washington, Inc. You must select and receive services from a provider in the Willamette Dental network.

6 Vision plan selection

Choose one vision plan in this section. Before you enroll, 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 by MetLife**, underwritten by Metropolitan Life Insurance Company ("MetLife")
- **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
- **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

Subscriber's last name

Social Security number

7 Account changes and special open enrollment

Are you making changes to an existing account?

☐ **Yes**

If Yes, what changes? (Check all changes that apply in the sections below.)

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

☐ **No**

If No, go to the next section.

Changes you can make anytime

If you have a name or address change, contact your payroll or benefits office.

☐ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child), your payroll or benefits office must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility for health plan coverage. If applicable, provide former dependent's new address:

Street address

Address line 2

City

State

ZIP/Postal code

County

Changes you can make during the SEBB Program's annual open enrollment

All changes become effective January 1 of the following year. Check the boxes next to the changes requested.

☐ Add dependents

☐ Remove dependents

☐ Change medical plan

☐ Change dental plan

☐ Change vision plan

☐ Enroll after waiving medical coverage

☐ Waive medical due to enrollment in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B.

Subscriber's last name

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

The SEBB Program only allows changes outside of annual open enrollment when an event creates an SOE for the employee, a dependent, or both. The change must be allowable under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with the event. You must provide proof of the event. Your payroll or benefits office must receive this form and proof of the event **no later than 60 days after the event occurs**.

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. If that day is the first of the month, the change begins on that day.

⚠ Many SOE events have restrictions on allowed changes. See SEBB Policy Addendum 45-2A on the *SEBB Rules and policies* webpage at **hca.wa.gov/sebb-rules** for details. If you need assistance, contact your payroll or benefits office.

Check the box next to the change you are requesting and the matching event.

- ☐ Add dependents
- ☐ Remove dependents
- ☐ Change medical plan
- ☐ Change dental plan
- ☐ Change vision plan
- ☐ Enroll after waiving medical coverage
- ☐ Waive medical coverage due to enrollment in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B.

Note: A health plan change is not allowed when adding an SRDP or their child if they are not a tax dependent.

The following events allow an employee to add dependents, remove dependents, change medical, dental, or vision plans, and enroll after waiving medical.

- ☐ Employee has a change in employment status that affects their eligibility for their employer contribution toward their employer-based group health plan.
- ☐ Employee's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan.
- ☐ Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ Marriage, registering a state-registered domestic partner (SRDP), as defined by WAC 182-31-020, birth, adoption, or assuming a legal responsibility for support ahead of adoption. You must also submit a *SEBB Declaration of Tax Status* if adding an SRDP or their child to indicate whether the dependent qualifies as a dependent for tax purposes.

The following events allow an employee to add dependents, enroll after waiving medical, and change medical, dental, or vision plans.

- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also submit a *SEBB Extended Dependent Certification*.
- ☐ Employee or dependent loses eligibility for other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ Employee or dependent becomes eligible for a state premium assistance subsidy for a SEBB health plan from Apple Health (Medicaid) or a state CHIP.

Subscriber's last name

Social Security number

The following event allows an employee to add dependents, remove dependents, enroll after waiving medical, and waive medical coverage.

- [ ] Employee or dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment. (Waiving medical coverage is allowed for this event only when an employee enrolls under another employer-based group health plan during its annual open enrollment.)

The following event allows an employee to add dependents, remove dependents, and enroll after waiving medical coverage.

- [ ] Employee's dependent moves from another country to live within the United States or moves from the U.S. to live in another country, and the move resulted in the dependent losing their health insurance.

The following event allows an employee to add dependents, remove dependents, change medical, dental, or vision plans, and enroll after waiving medical coverage.

- [ ] A court order that requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee.

The following events allow an employee to change medical, dental, or vision plans.

- [ ] Employee's or dependent's current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).
- [ ] Employee or dependent experiences a disruption of care that could function as a reduction in benefits for the employee or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program).
- [ ] Employee has a change in employment location that affects medical plan availability, or results in the employee having one or more new medical plans available.
- [ ] Employee or dependent has a change in residence that affects medical plan availability.

The following events allow an employee to add dependents, remove dependents, change medical plans, and enroll after waiving medical coverage.

- [ ] Employee gains or loses eligibility for Medicare.
- [ ] Dependent gains or loses eligibility for Medicare. For this event, employees can only add a dependent to coverage if the dependent lost eligibility for Medicare, and they can only remove a dependent from coverage if the dependent gained eligibility for Medicare.

The following event allows an employee to enroll after waiving medical and waive medical coverage.

- [ ] Employee or dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.

Subscriber's last name

Social Security number

8 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 is not complete until the SEBB Program verifies the eligibility of my dependents. I understand 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.

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 premium for medical coverage as well as a $25 monthly tobacco use premium surcharge.

Employees must enroll in SEBB dental, vision, basic life, basic accidental death and dismemberment, and employer-paid long-term disability (LTD) insurance. Enrollment in employee-paid LTD insurance is automatic. Employees can choose a lower cost coverage level or decline coverage.

Employees who choose to waive SEBB medical coverage must be enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B. 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.

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 surcharges in addition to my monthly premium.

I understand if I enroll in SEBB dental or vision, it is my responsibility to call the plan (not my provider) to verify my provider is covered by the dental plan network or vision plan network I selected.

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/change forms previously submitted, including any changes made in the online enrollment system.

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

Subscriber's signature

Date

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's website at **hca.wa.gov/sebb-employee**.

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Subscriber's last name

Social Security number

9 Employer

⚠ This section to be completed by your employer.

HCA code/organization number

Organization name

Organization name (continued)

Eligibility: Check one

☐ Subscriber is SEBB eligible

☐ Subscriber is locally eligible

Eligibility date

Effective date

Represented?

☐ Yes, if Yes date they became represented

☐ No

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Subscriber's last name

Social Security number

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 97232-5398
1-800-813-2000 (TRS: 711)

Kaiser Foundation Health Plan of Washington
2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc.
2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

Premera Blue Cross High PPO and Standard PPO
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357

Premera Blue Cross HMO
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)
PO Box 1106
Lewiston, ID 83501-1106
1-800-628-3481 (TRS: 711)

Uniform Medical Plan, administered by ArrayRx (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0327
1-888-361-1611 (TRS: 711)

Dental

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: 1-800-833-6384

Willamette Dental of Washington, Inc.
910 NE 82nd St.
Vancouver, WA 98665
1-855-433-6825 (TRS: 711)

Vision

Davis Vision by MetLife, underwritten by Metropolitan Life Insurance
200 Park Ave.
New York, NY 10166
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)
200 Park Ave.
New York, NY 10166
1-833-854-9624
TTY: 1-800-428-4833