Clear form

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

2021 School Employee Change

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

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

To make changes to your coverage during the annual open enrollment or a special open enrollment, go to SEBB My Account or submit this form to your payroll or benefits office.

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

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 7. To enroll children, complete Section 9 on pages 13 and 14.

1 Account changes and special enrollment

Date of event/change

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.

2021 School Employee Change

Subscriber's last name

Social Security number

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

The SEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. The changes must be allowable under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with a special open enrollment event for the employee, employee's dependent, or both. You are required to 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, enrollment or change will be effective the first day of the month following the later of the event date or the date this form is received.

What changes are you requesting? Check the box next to the change you are requesting and the corresponding event below.

- 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.

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

- Employee has a change in employment status that affects the employee's 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 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 Washington Administrative Code 182-31-140, birth, adoption, or assuming a legal responsibility for support ahead of adoption. You must also submit a *2021 SEBB Declaration of Tax Status* form if adding a SRDP or their child to indicate whether the dependent qualifies as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

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

- Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also submit a *2021 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 SEBB health plan from Apple Health (Medicaid) or a state CHIP.

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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 United States 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 plans, dental plans, and/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 plans, dental plans, and/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 from one school district (or any educational service district or any charter school) to another school district that results in the employee having different medical plans available.
- [ ] Employee or dependent has a change in residence that affects health plan availability.

The following events allow 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.
- [ ] Employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

2 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)

Mailing 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 (Dental cannot be waived)	✓ Cover (Vision cannot be waived)
☐ Waive		

! 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, basic long-term disability (LTD) insurance. If you waive medical coverage for yourself, you cannot enroll your dependents in SEBB medical coverage.

Are you or your dependents enrolled in SEBB insurance coverage under another account?

☐ Yes ☐ No **!** If Yes, please contact your payroll or benefits office for help.

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**.

2021 School Employee Change

Subscriber's last name

Social Security number

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 on HCA's website at **hca.wa.gov/sebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge. For instructions on how to respond, see the *2021 SEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/sebb-employee** under *Forms & publications*. To change your attestation use SEBB My Account or the *2021 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. If this is a change to a previous attestation, submit the *SEBB Premium Surcharge Attestation Change Form*.
- **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 *Premium Surcharge Attestation Help Sheet.*

Subscriber's last name

Social Security number

3 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or SRDP, as defined by WAC 182-31-140, you wish to enroll or remove from medical, dental, or vision coverage. To enroll children, please complete Section 9, 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. A list of acceptable documents to verify eligibility is available on HCA's website at **hca.wa.gov/sebb-employee**.

Your spouse or SRDP cannot be enrolled in two SEBB Program medical, dental, and vision accounts at the same time.

Relationship to subscriber. Choose one.

☐ Spouse: date of marriage

☐ SRDP: date registered

If enrolling a SRDP, also submit a *2021 SEBB Declaration of Tax Status* 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

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's)

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
☐ 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 *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

Social Security number

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.

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. If this is a change to a previous attestation, submit the *SEBB Premium Surcharge Attestation Change* form.
- **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.

Does the spouse or SRDP coverage premium 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 $50 spouse or SRDP coverage 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, if any, 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 completing and submitting a printed *SEBB Spousal Plan Calculator*. My employer will use these to help determine whether my spouse's or SRDP's employer-based group medical is comparable to PEBB's UMP Classic and whether I am subject to this premium surcharge.

! The *2021 SEBB Premium Surcharge Attestation Help Sheet* and *the 2021 SEBB Spousal Plan Calculator* are available on HCA's website at **hca.wa.gov/sebb-employee** under *Forms & publications*.

Subscriber's last name

Social Security number

4 Medical plan selection

Choose one medical plan.

Kaiser Foundation Health Plan of the Northwest[1]

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

Kaiser Foundation Health Plan of Washington

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

Kaiser Foundation Health Plan of Washington Options, Inc.

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

Premera Blue Cross

- ☐ Premera High PPO
- ☐ Premera Peak Care EPO
- ☐ Premera Standard PPO

Uniform Medical Plan (UMP),
administered by Regence BlueShield

- ☐ 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** and in the enrollment guide. Contact the plans with questions about benefits and provider information. (Contact information is on page 12 of this form.) Before you enroll, make sure that the provider you want to use accepts the specific plan you choose by calling the health plan to check. When you call the plan, specify which plan you are wanting to know about because not all providers are in the same plan provider networks.

These plans have specific service areas. You must live or work in the medical plan's service area to enroll in the plan. All school employees are offered a selection 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 in to see all plan options available to you. Exception: 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 (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] Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

[2] 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.

Subscriber's last name

Social Security number

5 Dental plan selection

Choose one dental plan in this section. Before you enroll, 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.

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. Before you enroll, call DeltaCare at 1-800-650-1583 to make sure that the provider you want to use accepts the specific plan you choose.

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 the specific plan and plan group you choose.

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, underwritten by HM Life Insurance Company

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company

MetLife Vision, underwritten by Metropolitan Life Insurance Company

Carrier contact information is on page 12.

Subscriber's last name

Social Security number

7 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 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 basic long-term disability insurance[1]. 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.

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 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. Any changes made on SEBB My Account or SEBB enrollment or change forms submitted and dated later than this form will replace this enrollment form.

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

Subscriber's signature

Date

Continue to Section 9 to add or remove dependents.

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**.

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

2021 School Employee Change

Subscriber's last name

Social Security number

8 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

2021 SEBB Program contractors

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

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
1-888-901-4636
TTY: 1-800-833-6388 (TRS: 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 (TRS: 711)

Premera Blue Cross
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)
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)

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: 1-800-833-6384

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)
TTY: 711

Vision contractors

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
1-855-MET-EYE1 (1-855-638-3931)
TTY: 1-800-428-4833

Subscriber's last name

Social Security number

9 Dependents

List eligible dependents you wish to enroll or remove from coverage. 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 and children age 26 or older with a disability. A list of documents we will accept to verify eligibility is available on HCA's website at **hca.wa.gov/sebb-employee**. Use additional forms for more dependents.

If adding a state-registered domestic partner's child, extended dependent, or other nonqualified tax dependent, also attach a *2021 SEBB Declaration of Tax Status* 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 *2021 SEBB Extended Dependent Certification*, a valid court order showing legal custody or guardianship, and a *2021 SEBB Declaration of Tax Status.*

If enrolling a child with a disability age 26 or older, attach a *2021 SEBB Certification of a Child with a Disability* and submit it 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

Dependents cannot be enrolled in two SEBB medical, dental, and vision accounts.

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's)

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
☐ 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 *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

Social Security number

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 *2021 SEBB Premium Surcharge Attestation Help Sheet* available on HCA's website 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 dependent has used tobacco products in the past two months. If this is a change to a previous attestation, submit the *SEBB Premium Surcharge Attestation Change Form*.
- **No,** I am not subject to the $25 premium surcharge. This dependent has not used tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet.*

Use additional forms to list more dependents.