

Insurance Eligibility Adjustment Form

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| --- | --- | --- | --- | --- | --- | --- |
| **Agency/Sub Agency Number** | | **Agency Name** | | | | |
| **Employee Name (Last, First)** | **Employee’s**  **Full SSN**  **(000-00-0000)** | **Employment Termination Effective Date** | **Insurance Termination Effective Date\*** | **Termination Reason\*** | **Salary Change** | |
| **Date Salary Changed** | **New Gross Monthly Salary** |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |

**\* Insurance Termination Effective Date** is always the last day of a month (i.e. May 31, or Nov 30). Coverage lasts for the entire month in which the employee has at least 8 hours of pay status.

**\*Termination reasons** include but are not limited to:

* Employment ending, retirement, death, gross misconduct
* Approved LWOP (disability retirement, layoff, USERRA [military] leave, educational leave, etc.)

Prepared by       Date       Phone Number       Email

Keep a copy for your files and submit to PEBB Program by:

* Sending a secure message through HCA Support at [**support.hca.wa.gov**](https://support.hca.wa.gov/hcasupport), or
* Faxing to 360-725-0771, or
* Mailing to Health Care Authority, Attn: Outreach & Training, PO Box 42684, Olympia, WA 98504-2684

How to complete the form

The following data needs to be entered on the form:

1. **Agency/Sub Agency:** Your agency and sub-agency number (HCA agency account number).
2. **Agency Name:** Your agency name.
3. **Employee Name (Last, First):** The last and first name of the employee needing a change.
4. **Employee SSN:** The SSN of the employee needing a change.
5. **Employment Termination Effective Date**: Date the employment relationship is ending.
6. **Insurance Termination Effective Date:** If the employee’s insurance is to be terminated, enter the date insurance ends (always the last date of the month).
7. **Termination Reason\*:** The reason why insurance is being terminated.
8. **Date Salary Changed:** The effective date of the employee’s salary change (increase or decrease). The change will affect insurance for the month after the change is effective.
9. **New Gross Monthly Salary:** The new gross monthly salary of the employee if a salary change is being reported.
10. **Prepared By:** The name of the person preparing the form.
11. **Date:** The date the form is completed
12. **Phone Number:** The phone number of the person who prepared the form.
13. **Email:** The email address of the person who prepared the form.

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| --- | --- | --- | --- | --- | --- | --- |
| **Agency/Sub Agency Number**  900 B89 | | **Agency Name**  Ben Franklin Transit | | | | |
| **Employee Name (Last, First)** | **Employee’s**  **Full SSN**  **(000-00-0000)** | **Employment Termination Effective Date** | **Insurance Termination Effective Date\*** | **Termination Reason\*** | **Salary Change** | |
| **Date Salary Changed** | **New Gross Monthly Salary** |
| Smith, Doug | xxx-xx-xxxx | June 22nd | June 30th | Retirement |  | $ |
| Jones, Shirley | xxx-xx-xxxx |  |  |  | July 8th | $ 3, 058.00 |
|  |  |  |  |  |  | $ |
|  |  |  |  |  |  | $ |
|  |  | **SAMPLE** |  |  |  | $ |