Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

EXAMPLE ONLY

Clear Form

A

2018 Retiree Coverage Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **List eligible family members you wish to cover or remove from coverage. This form replaces all election forms previously submitted.**
- If you are applying to enroll in retiree insurance coverage, the PEBB Program must receive this form **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are a new retiree deferring enrollment in PEBB retiree insurance coverage, the PEBB Program must receive this form **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. You must maintain continuous enrollment in other qualifying insurance coverage (see Section 1). Complete required sections below, Sections 1 and 9, and if applicable, Sections 7 and 8.
- If you are applying to enroll in PEBB retiree insurance coverage after a deferral, the PEBB Program must receive this form **no later than 60 days** after your other qualifying insurance coverage ends (see Section 1 of this form).
- If you are a surviving spouse, surviving state-registered domestic partner (defined in WAC 182-12-260(2)), or surviving dependent, provide the Social Security number (SSN) of the deceased retiree or employee in the "Retiree or employee information only" section below. Provide your SSN and information in Section 1: Subscriber Information.

Additional forms or documents you may need to complete and submit:

- If enrolling in Premera Blue Cross Medicare Supplement Plan F, submit the *Group Medicare Supplement Enrollment Application* (form B).
- If enrolling in a Medicare Advantage plan, submit the *Medicare Advantage Plan Election Form* (form C).
- If enrolling a state-registered domestic partner or the partner's child, submit the *Declaration of Tax Status* form.
- If adding a dependent with a disability age 26 or older, submit the *PEBB Certification of Dependent With a Disability* form and return as instructed on the form.
- If adding an extended dependent, submit the *Extended Dependent Certification* form.
- **Dependent verification documents may be required. A list of documents we will accept to show proof of a dependent's eligibility is in the *2018 Retiree Enrollment Guide* and on our website at www.hca.wa.gov/pebb.**

These forms are available at **www.hca.wa.gov/pebb** or by calling 1-800-200-1004.

Check one:

☒ **Enroll:** I am a new retiree or a surviving dependent applying for coverage.
☐ **Deferring:** I am a new or existing retiree or a surviving dependent **deferring** my coverage.
☐ **Changing:** I am requesting **a change** to an existing account (such as canceling coverage, or adding or removing a family member).
☐ **Enrolling after deferring.** Date other coverage ended _____ (mm/dd/yyyy).
☐ **Separating:** Eligible under Plan 3 retirement plan, **separating** as of _____ (mm/dd/yyyy).

Required			
Retiree or employee information only	Retiree or employee name Harry Husky		
	Social Security number 123-45-6798	Retirement plan	Retirement date (mm/dd/yyyy) 07/01/2018
For new Washington State school district, charter school, or educational service district (ESD) retirees only	School district N/A		
	When does your current medical/dental coverage through your school district, charter school, ESD, or COBRA end? _____ (mm/dd/yyyy). **Note:** If you are applying to enroll in retiree insurance coverage after your COBRA coverage ends, you must submit proof of your continuous health coverage with this form.		

HCA is committed to providing equal access to our services.
If you need accommodation, please call 1-800-200-1004 or 711 for relay services.

(continued)

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Section 1: Subscriber Information

Social Security number	Last name	First name	Middle initial	Sex
123-45-6789	Husky	Harry		☒ M ☐ F

Street address	Apt./unit number	City	State	ZIP Code
123 Main Street		Seattle	WA	98119
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Home phone number (with area code)	Alternate phone number (with area code)
King	05/01/1950	(206) 123-4567	( )

Section 1: Enrollment Election/Change *Check the boxes that apply to you.*

☒ **Enroll:** ☐ Medical only ☐ Medical and dental ☐ Retiree term life insurance (also complete Sections 7, 8 and 9)

☐ **Defer my coverage.** Check the medical coverage below that allows you to defer PEBB retiree insurance coverage. Except as stated below, this defers coverage for all family members.
Deferral date _____

☐ **Enroll after deferring coverage.** Check the medical coverage below that you have been enrolled in since deferring enrollment in PEBB retiree insurance coverage. You will need to provide proof.
Date other coverage ended _____

If deferring or enrolling after deferring, check the box below that applies to you. When enrolling after deferring, you must provide proof of continuous coverage since your date of deferral (begin and end dates).

- ☐ Enrolled in a PEBB Program, Washington State school district, charter school, or educational service district-sponsored health plan as a dependent.
- ☐ Enrolled in employer-based group medical as an employee or employee's dependent, including COBRA coverage or continuation coverage. This does not include an employer's retiree coverage.
- ☐ Enrolled in medical coverage as a retiree or dependent in TRICARE or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in PEBB retiree insurance coverage.
- ☐ Enrolled in a Medicaid program that provides creditable coverage **and** in Medicare Part A and Part B. (You may continue to cover eligible family members who are not eligible for creditable coverage under Medicaid.)
- ☐ Non-Medicare retirees only: Enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in PEBB retiree insurance coverage.

☐ **Cancel: I am enrolled in PEBB retiree insurance coverage; I want to make the following change(s):**

☐ **Cancel medical** (if enrolled in only medical) **and dental coverage** (if enrolled in both). Cancel date _____
I understand I am forfeiting all further rights to enroll again unless I regain eligibility. Coverage is automatically canceled for any enrolled dependents.

☐ **Cancel dental coverage for myself and any dependents.** Cancel date _____
I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB retiree dental plan for at least two years or if I am deferring or disenrolling from my PEBB coverage as allowed under PEBB rules (see Section 6). If I cancel for myself, dental is automatically canceled for my enrolled dependents.

If you want to cancel retiree term life insurance, contact MetLife at 1-866-548-7139

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of your Medicare card to this form if we don't already have a copy.	Part A (hospital)	☒ Yes	☐ No	If yes, effective date 05/01/2015
	Part B (medical)	☒ Yes	☐ No	If yes, effective date 07/01/2018
Enrolled in Medicare Part D (prescription-drug coverage) If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross.		☐ Yes	☒ No	If yes, effective date _____
Enrolled in Medicaid with Medicare Part D?		☐ Yes	☒ No	If yes, effective date _____
Receiving Social Security Disability?		☐ Yes	☒ No	If yes, effective date _____

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B and you or a family member (age 13 or older) enrolled on your PEBB medical 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 you check YES below or leave this section blank, you will pay the surcharge.*** *See the* 2018 Premium Surcharge Help Sheet at **www.hca.wa.gov/pebb** *for instructions on how to respond.*

Does the tobacco use premium surcharge apply to you? Read each option carefully and check only one:

☒ I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **YES, I am subject to the $25 surcharge.** I have used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 surcharge.** I have not used tobacco products in the past two months, or I have used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet.*

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner (as defined in WAC 182-12-260(2)) you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If you are not enrolled in Medicare Part A and Part B you must provide proof of eligibility (dependent verification documents) within PEBB's enrollment timelines to enroll a spouse or state-registered domestic partner.***

Relationship to subscriber

☒ Spouse: date of marriage 08/01/1985

☐ State-registered domestic partner: date registered _____

If adding a state-registered domestic partner, attach a completed *Declaration of Tax Status* form and proof of eligibility within PEBB's enrollment timelines.

Social Security number	Last name	First name	Middle initial	Sex
987-65-4321	Husky	Mary		☐ M ☒ F

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code
123 Main Street	Seattle	WA	98119

Coverage for spouse or state-registered domestic partner

☐ Cover ☐ Remove. Attach a copy of divorce decree or dissolution of state-registered domestic partnership if removing a spouse or state-registered domestic partner for this reason.

Effective date _____ Reason _____

Date of birth (mm/dd/yyyy)

Enrolled in Part(s) A and/or B of Medicare?
If yes, proof is required. Attach a copy of your family member's Medicare card to this form.

Part A (hospital) ☒ Yes ☐ No If yes, effective date 05/01/2015

Part B (medical) ☒ Yes ☐ No If yes, effective date 07/01/2018

Enrolled in Medicare Part D (prescription-drug coverage)
If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. ☐ Yes ☒ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ☐ Yes ☒ No If yes, effective date _____

Receiving Social Security Disability? ☐ Yes ☒ No If yes, effective date _____

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Read each option and check only one:

☒ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **YES, I am subject to the $25 surcharge.** My spouse or state-registered domestic partner has used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 surcharge.** My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B and your spouse or state-registered domestic partner has chosen not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2018 Premium Surcharge Help Sheet *in the* 2018 Retiree Enrollment Guide *or at* **www.hca.wa.gov/pebb** *for instructions.* ***If you check YES below or leave this section blank, you will pay the monthly surcharge.***

Does the spouse or state-registered domestic partner coverage surcharge apply to you? Read each option carefully and check only one:

☒ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ I previously attested to the spousal coverage premium surcharge and my attestation has not changed.

☐ **YES, I am subject to the $50 surcharge.** I used the *2018 Premium Surcharge Help Sheet* and completed the *2018 Spousal Plan Calculator.*

☐ **NO, I am not subject to the $50 surcharge.** I used the *2018 Premium Surcharge Help Sheet* (and, if needed, completed the *2018 Spousal Plan Calculator* online.)

Which questions (if any) on the *2018 Premium Surcharge 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

☐ I am completing and submitting the *2018 Spousal Plan Calculator* found at **www.hca.wa.gov/pebb** for the PEBB Program to determine.

(continued)

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 3: Family Member Information *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If you are not enrolled in Medicare Part A and Part B, you must provide proof of your family member's eligibility (dependent verification documents) within the PEBB Program's enrollment timelines or your family member will not be enrolled.*** *If enrolling a state-registered domestic partner's child, attach a completed* Declaration of Tax Status *form. If enrolling a dependent with a disability age 26 or older, submit a completed* Certification of Dependent With a Disability *form and return as instructed on the form. Attach an* Extended Dependent Certification *form if enrolling an extended dependent.*

1 **Relationship to subscriber** | Last name | First name | Middle initial

Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ M ☐ F	Disabled? *(Check only if age 26 or older)* ☐ Yes ☐ No	Extended dependent validated by court order? ☐ Yes ☐ No

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Coverage for family member ☐ Cover ☐ Remove Effective date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of your family member's Medicare card to this form.
Part A (hospital) ☐ Yes ☐ No If yes, effective date _____
Part B (medical) ☐ Yes ☐ No If yes, effective date _____

Enrolled in Medicare Part D (prescription-drug coverage) If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. ☐ Yes ☐ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ☐ Yes ☐ No If yes, effective date _____

Receiving Social Security Disability? ☐ Yes ☐ No If yes, effective date _____

Does the tobacco use premium surcharge apply to this family member?
Response required for family members ages 13 or older. Read each option carefully and check only one:

☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **YES, I am subject to the $25 surcharge.** This family member has used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 surcharge.** This family member has not used tobacco products in the last two months or has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

2 **Relationship to subscriber** | Last name | First name | Middle initial

Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ M ☐ F	Disabled? *(Check only if age 26 or older)* ☐ Yes ☐ No	Extended dependent validated by court order? ☐ Yes ☐ No

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Coverage for family member ☐ Cover ☐ Remove Effective date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare? If yes, proof is required. Attach a copy of your family member's Medicare card to this form.
Part A (hospital) ☐ Yes ☐ No If yes, effective date _____
Part B (medical) ☐ Yes ☐ No If yes, effective date _____

Enrolled in Medicare Part D (prescription-drug coverage) If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross. ☐ Yes ☐ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ☐ Yes ☐ No If yes, effective date _____

Receiving Social Security Disability? ☐ Yes ☐ No If yes, effective date _____

Does the tobacco use premium surcharge apply to this family member?
Response required for family members ages 13 or older. Read each option carefully and check only one:

☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **YES, I am subject to the $25 surcharge.** This family member has used tobacco products in the past two months.

☐ **NO, I am not subject to the $25 surcharge.** This family member has not used tobacco products in the last two months or has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

(continued)

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 4: Changes to an Enrolled Retiree Account

Are you making changes to an enrolled retiree account?

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

☒ No *If no, go to Section 5.*

Changes you can make anytime

☐ Name change ☐ Address change Give date of event/change _____

☐ Remove dependent(s). In most cases, when removing a dependent from coverage the change will occur prospectively. If removing a dependent due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB Program benefits), you must submit this form **no later than 60 days** after the last day of the month the dependent loses eligibility for health plan coverage. Coverage will be canceled the last day of the month of loss of eligibility. If applicable, provide former dependent's new address _____

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of an annual open enrollment when an event creates a special open enrollment. The PEBB Program must receive this form and proof of the event that created the special open enrollment **no later than 60 days after the event.** However, if adding a newborn or adopted child increases your premium, this form must be received no later than 12 months after the date of the birth or adoption.

Check the box next to each change you are requesting, and indicate the corresponding event(s) below.
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.

☐ Add dependent(s) ☐ Change medical and/or dental plan Give date of event _____

The following events allow a subscriber to add a dependent and change a medical and/or dental plan:

☐ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.

☐ Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form available at **www.hca.wa.gov/pebb**.

☐ Subscriber or subscriber's dependent losing other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).

☐ Subscriber having a change in employment status that affects his or her eligibility for the employer contribution toward his or her employer-based group health plan.

☐ Subscriber's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.

☐ A court order or National Medical Support Notice requiring the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.

☐ Subscriber or dependent becoming entitled to or losing eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).

☐ Subscriber or dependent becoming eligible for a state premium assistance subsidy for PEBB Program health plan coverage from Medicaid or CHIP.

The following events allow a subscriber to add a dependent:

☐ Dependent having a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.

☐ Subscriber's dependent moving from outside of the United States to within the United States, or from within the United States to outside of the United States.

The following events allow a medical and/or dental plan change:

☐ Subscriber or dependent having a change in residence that affects health plan availability.

☐ Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

☐ Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare, or enrolling (or terminating enrollment) in a Medicare Part D plan.

☐ Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).

(continued)

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 5: Medical Plan Selection *Check appropriate box(es).*

Contact the plans for benefits information; their contact information is at the end of this form.

Kaiser Foundation Health Plan of Washington[7]
(formerly Group Health Cooperative)

- ☐ Kaiser Permanente WA (formerly Group Health) Classic
- ☒ Kaiser Permanente WA (formerly Group Health) Medicare Plan[1,2]
- ☐ Kaiser Permanente WA (formerly Group Health) SoundChoice[3]
- ☐ Kaiser Permanente WA (formerly Group Health) Value

Kaiser Foundation Health Plan of Washington Options, Inc.[7]
(formerly Group Health Options Inc.)

- ☐ Kaiser Permanente WA (formerly Group Health) Consumer-Directed Health Plan[4]

Kaiser Foundation Health Plan of the Northwest[7]

- ☐ Kaiser Permanente NW Classic[8]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[8]
- ☐ Kaiser Permanente NW Senior Advantage[1]

☐ **Medicare Supplement Plan F, administered by Premera Blue Cross**[5]

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan[4]

UMP Plus (select one network below)

- ☐ UMP Plus—Puget Sound High Value Network[6, 7]
- ☐ UMP Plus—UW Medicine Accountable Care Network[6, 7]

[1] These Medicare Advantage plans are available in certain counties to Medicare enrollees. Also complete and attach form C if you live in a county where Medicare Advantage is available.

[2] If you cover members not enrolled in Medicare Part A and Part B, also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.

[3] This plan is available only if at least one member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA's Medicare Plan.

[4] These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.

[5] Also complete and return form B to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.

[6] This plan is not available to Medicare Part A and Part B retirees and their dependents.

[7] These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program **no later than 60 days** after you move.

[8] Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.

Section 6: Dental Plan Selection *Check only one.*

You must enroll in medical coverage to enroll in dental. You cannot enroll in ONLY dental coverage.

If you select retiree dental coverage for yourself, **you must keep dental coverage for yourself and any enrolled dependents for at least two years** unless you defer or cancel enrollment in PEBB dental as described in PEBB Program rules (WAC 182-12-208). However, you may change retiree dental plans within those two years during the PEBB Program's annual open enrollment (November 1-30), or due to a special open enrollment event.

Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans for benefits information; their contact information is located at the end of this form.

Preferred Provider Organization (PPO)

☒ **Uniform Dental Plan** (Group #3000), 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 #3100), administered by Delta Dental of Washington
You will select and receive care from a primary care dental provider in the DeltaCare network. **Before you enroll, call DeltaCare at 1-800-650-1583** to verify your provider accepts the specific plan network and plan group.

☐ **Willamette Dental of Washington, Inc.** (Group WA82)
You will select and receive care from a primary care dental provider in the Willamette Dental Group plan.

(continued)

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 7: Retiree Term Life Insurance Election

Retiree term life insurance is available only if you receive PEBB life insurance as an employee. Disabled retirees who qualify for a waiver of premium benefit under the PEBB employee life insurance plans are not eligible for the retiree term life insurance plan.

To apply for retiree term life insurance, complete and return the *MetLife Enrollment/Change Form for Retiree Plan* (including the beneficiary designation) to the PEBB Program with this form.

❑ I acknowledge that I have completed the *MetLife Enrollment/Change Form for Retiree Plan* and will return it with this form.

If you want your retiree term life insurance premium to be deducted from your Department of Retirement Systems pension, complete and sign **Section 8: Payment Authorization** below. Otherwise, you will receive a bill directly from MetLife for your retiree term life insurance premiums.

Section 8: Payment Authorization

How would you like to pay your medical, dental, and life insurance premiums (if elected) and any applicable premium surcharges?	How to make the first payment
❑ **Pension Deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and any applicable surcharges I am required to pay from my **retirement pension.** Deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.	If you select pension deduction, the PEBB Program will send you an invoice if a first payment is needed. You will receive an invoice and must pay by check until your pension deduction is set up.
❑ **Invoicing: I must make the first payment before I will be enrolled.** I will pay my medical and dental (if elected) premiums and any applicable surcharges monthly by **check.** I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. ❑ **Electronic Debit Service (EDS): I must make the first payment for my medical and dental (if elected) premiums before I will be enrolled.** I will complete and submit the *Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. I will pay my monthly premium(s) and any applicable surcharges by check until notified of my EDS effective date. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. To pay by EDS for your retiree term life insurance, contact MetLife at 1-866-548-7139.	If you select one of the options at the left for your medical and dental premiums only, make your check **payable to Health Care Authority** and send with your forms to: Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695

Note: You cannot have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage, COBRA coverage, or continuation coverage ended. Premiums and any applicable surcharges are for a full month of coverage and cannot be prorated for a partial month. Payments are processed immediately as required by state law.

(continued)

EXAMPLE ONLY

2018 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 9: Signature *Required*

By signing 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 PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime and can result in imprisonment, fines, and denial of PEBB benefits.

If I send payment, this does not mean I will be automatically enrolled in PEBB retiree insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund of premium payments.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly premium (if I am not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, I must remain enrolled in retiree dental for at least two years unless I defer coverage as described in Section 1, or enroll in employer-based group dental insurance or such coverage continued under COBRA as an employee or dependent of an employee.

I also understand that it is my responsibility to verify my dentist is covered by the dental plan network I selected.

I understand if I or any enrolled family member is entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.

If I choose to defer medical/dental, I understand I can enroll or reenroll **no later than 60 days** after losing other health coverage or during the PEBB Program's annual open enrollment period (November 1-30) as long as there has been no gap in coverage and I provide proof of continuous enrollment. The PEBB Program must receive my enrollment form **no later than 60 days** after other coverage ends, or the last day of the PEBB Program's annual open enrollment period. If I defer enrollment for myself, I cannot enroll my eligible family members. I understand in most cases, enrollment will be deferred effective the first of the month following the date this form is received by the PEBB Program unless a future date is provided.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand the PEBB Program will direct a portion of my monthly premium to an HSA 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.

If I die, my eligible surviving family members must complete the *Retiree Coverage Election/Change* form to enroll in or defer PEBB retiree health insurance coverage. The PEBB Program must receive the form **no later than 60 days** after my death.

This form replaces all *Retiree Coverage Election/Change* forms previously submitted to the PEBB Program. If I am a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with DRS to better serve me.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

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

Subscriber's signature Harry Husky **Date** 06/01/2018

Be sure to sign and date this form and keep a copy for your records. Mail completed form and documentation to:
Washington State Health Care Authority, PEBB Program, P.O. Box 42684, Olympia, WA 98504-2684 **or fax to:** 360-725-0771
Questions? Visit our website at **www.hca.wa.gov/pebb** or call us at 1-800-200-1004.
For new enrollment, deferral, or cancellation, the PEBB Program will send you a confirmation letter after your form is processed.

2018 PEBB Medical Contractors

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 711

Kaiser Foundation Health Plan of Washington
(formerly Group Health Cooperative)
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc.
(formerly Group Health Options, Inc.)
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Premera Blue Cross
P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Avenue, Suite 235, Seattle, WA 98101
1-888-849-3681 or TRS 711

2018 PEBB Dental Contractors

DeltaCare,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800 Seattle, WA 98109-5371
1-800-650-1583

Uniform Dental Plan,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800 Seattle, WA 98109-5371
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-433-6825

2018 PEBB Program Life Insurance Contractor

Metropolitan Life Insurance Company (MetLife) MetLife
Recordkeeping Center
PO Box 14406, Lexington KY 40512-4406
(Plan #164995-1-G)
1-866-548-7139

EXAMPLE ONLY

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Clear Form C

2018 Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read and sign the back of this form.

Section 1: Retiree information					Medical effective date (mm/dd/yyyy) 07/01/2018
Social Security number 123-45-6789	Last name (as it appears on Medicare card) Husky	First name Harry	Middle initial	Sex ☒ M ☐ F	
Permanent residential address (required) 123 Main Street	Apt./unit number	City Seattle	State WA	ZIP Code + 4 98119	
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code + 4	

County of residence	Date of birth (mm/dd/yyyy)	☒ Married (mm/dd/yyyy)	Home phone number (with area code)
King	05/15/1950	08/01/1985	206-123-4567

Retiree Medicare claim number from Medicare card		
123-45-6789 A	**Entitled to Part A (hospital)**	☒ Yes ☐ No If yes, effective date 05/01/2015
	Entitled to Part B (medical)	☒ Yes ☐ No If yes, effective date 07/01/2018

Section 2: Spouse or state-registered domestic partner information *(If applying)*				
Social Security number 987-65-4321	Last name (as it appears on Medicare card) Husky	First name Mary	Middle initial	
Permanent residential or mailing address 123 Main Street		Date of birth 07/01/1950	Sex ☐ M ☒ F	
City Seattle		State WA	ZIP Code + 4 98119	

Spouse or state-registered domestic partner's Medicare claim number from Medicare card		
987-65-4321 A	**Entitled to Part A (hospital)**	☒ Yes ☐ No If yes, effective date 05/01/2015
	Entitled to Part B (medical)	☒ Yes ☐ No If yes, effective date 07/01/2018

Section 3: Plan choice

Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)
☒ Kaiser Permanente WA (formerly Group Health) Medicare Advantage

Kaiser Foundation Health Plan of the Northwest
☐ Kaiser Permanente NW Senior Advantage

Name of RETIREE'S contracting primary care provider (refer to plan's provider directory)	Current patient?
Dr. John Do	☒ Yes ☐ No
Name of SPOUSE'S or STATE-REGISTERED DOMESTIC PARTNER'S contracting primary care provider (refer to plan's provider directory)	Current patient?
Dr. Mary Do	☒ Yes ☐ No

(continued)

HCA is committed to providing equal access to our services.
If you need accommodation, please call 1-800-200-1004 or 711 for relay services.

EXAMPLE ONLY

Section 4: Medical information	Retiree	Spouse or state-registered domestic partner
1. Do you currently have end-stage renal disease (kidney disease)?	☐ Yes ☒ No	☐ Yes ☒ No
2. Do you have any health insurance other than Medicare?	☒ Yes ☐ No	☒ Yes ☐ No
If yes, through which company? PEBB Employer Coverage	What type of policy? Group Medical	
Do you intend to discontinue this policy?	☐ Yes ☒ No	☐ Yes ☒ No
Note: Your answers to questions 3 and 4 below will **not** affect your eligibility to enroll in a Medicare Advantage plan.		
3. Do you live in an institution?	☐ Yes ☒ No	☐ Yes ☒ No
If yes, name of institution:	Date of admission:	
Address:	Phone number:	
4. Are you currently receiving Medicaid?	☐ Yes ☒ No	☐ Yes ☒ No
If yes, Medicaid number:		

Signature and authorization

By signing 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 PEBB Program rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

I have read and understand this form, including the Statement of Understanding (on the next page). I know that I must refer to my plan's certificate of coverage for rules I must follow to receive coverage under this Medicare Advantage contract.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB Program rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

This form cannot be signed more than 90 days before the effective date of this coverage. (*See Statement of Understanding on the next page for Medicare Advantage Plan coverage effective date.)

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

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS to better serve you.

Signature of applicant	Date	Signature of spouse or state-registered domestic partner (if enrolling)	Date
Harry Husky	06/01/2018	Mary Husky	06/01/2018

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where he or she resides) on this application means that I have read and understand the contents of the application. If signed by an authorized representative (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from the Medicare Advantage plan or by Medicare.

If you are the authorized representative, you must sign below and provide the following information:

Signature of authorized representative	Date

Name	Relationship to applicant
Address	**Phone**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the first page of this form, all medical services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage plan will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage plan will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision or coordination of benefits or to professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

*I understand that my enrollment in the Medicare Advantage plan I have selected is effective the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during the PEBB Program's annual open enrollment (November 1-30), then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date of enrollment. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date of enrollment.

Please contact the plans listed below if you need information in another language or format.

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of the Northwest are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.

2018 PEBB MEDICAL CONTRACTORS

Kaiser Foundation Health Plan of Washington
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY: 1-800-833-6388 or 711

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-877-221-8221 or TTY: 711

Please return this form by mail to:

Washington State Health Care Authority
P.O. Box 42684, Olympia, WA 98504-2684
or fax to: 360-725-0771

EXAMPLE ONLY

Electronic Debit Service is only available to continuously enrolled self-pay PEBB subscribers. If you are making your first payment, you need to pay by check or money order.

Electronic Debit Service Agreement

Washington State Health Care Authority
Public Employees Benefits Board

Electronic debit service (EDS) allows PEBB subscribers to have monthly payments automatically taken from a checking or savings account. To get started, please complete this form. Type or print clearly in black ink.

I am submitting this form to (check one):

☒ Start an electronic debit service from my bank account.

☐ Change my electronic debit service bank account.

Subscriber's Information

Subscriber's name (please print)	PEBB account number or subscriber's Social Security number
Harry Husky	123-45-6789

Bank Account Information

Account holder's name (if different from above; please print)

Name of financial institution	Branch address
Bank of America	4701 University Way

City	State	ZIP Code	Bank routing number
Seattle	WA	45789	1234567889

☒ Checking ☐ Savings (Check one)

Account number: 45789

I hereby authorize the Health Care Authority (HCA) to start electronic funds transfers from the financial institution named above. I understand my authorization remains in effect until I give written notice to the HCA, which I must do at least 15 business days before my next monthly withdrawal. If I want to change the checking or savings account that HCA withdraws from, I will submit a new Electronic Debit Service Agreement form at least 15 business days before the next withdrawal.

Withdrawals will occur on the 15th day of each month that I have insurance coverage and will be in the amount of my monthly invoice. If the 15th falls on a Saturday, Sunday, or holiday, the withdrawal will occur on the next business day. The HCA will notify me of payments returned for insufficient funds or closed accounts, and provide payment instructions.

The HCA reserves the right to change or terminate this agreement as an account payment method for any reason and at any time by giving proper notice of at least 15 business days.

Signature **(Must be signed by account holder to authorize debit service)**	Date
Harry Husky	07/01/2018

To complete your authorization process:

☒ Make sure you have filled out the entire form, including your signature above.

☒ Enclose a **voided check** or a **deposit slip**, and send to:

Washington State Health Care Authority
Attn: Accounting
P.O. Box 42691
Olympia, WA 98504-2691

Remember!

You must continue to pay your premium invoices until you receive a letter from the HCA with your EDS start date. EDS approval takes six to eight weeks.

You must submit a new Electronic Debit Service Agreement form to HCA when your bank account information changes.

If you have questions or would like more information, call the HCA Accounting Office at 1-800-200-1004.