Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

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2017 Retiree Coverage Election/Change

- **Use this form to enroll, defer, or make changes to PEBB retiree insurance coverage.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- If you are applying to enroll in retiree health insurance, 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 deferring enrollment in PEBB retiree health insurance, 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 health insurance 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).
- List eligible family members you wish to cover or remove from coverage. This form replaces all election forms previously submitted.
- If you are a surviving spouse, surviving state-registered domestic partner as 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 in Section 1: Subscriber Information.

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

- If enrolling in a plan that offers Medicare Advantage, submit the *Medicare Advantage Plan Election Form* (form C).
- If enrolling in the Premera Blue Cross Medicare Supplement Plan F, submit the *Group Medicare Supplement Enrollment Application* (form B).
- 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.
- 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 *2017 Retiree Enrollment Guide* and on our website.**

These forms are available at
www.hca.wa.gov/public-employee-benefits
or by calling 1-800-200-1004.

Required **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, **separating** as of _____ (mm/dd/yyyy).

Required **Retiree or employee information only**	Retiree or employee name		
	Social Security number	Retirement plan	Retirement date (mm/dd/yyyy)
For new Washington State school district, charter school, or educational service district (ESD) retirees only	School district		
	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.		

(continued)

2017 Retiree Coverage Election/Change

Section 1: Subscriber Information

Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code
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 (including area code) ( )	Alternate phone number (including area code) ( )

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.** Identify below your medical coverage that allows you to defer PEBB retiree coverage. Except as stated below, this defers coverage for all family members.
Deferral date _____

❑ **Enroll after deferring coverage.** Identify below the medical coverage you have been enrolled in since deferring enrollment in PEBB retiree coverage.

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 coverage.

❑ Enrolled in Medicare Part A **and** Part B **and** a Medicaid program that provides creditable coverage. (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 coverage.

❑ **Cancel: I am enrolled in PEBB retiree 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.

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 _____
	Part B (medical)	❑ Yes ❑ No	If yes, effective date _____
Enrolled in Part D (prescription-drug coverage) of Medicare? 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 Program medical coverage 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* 2017 Premium Surcharge Help Sheet at **www.hca.wa.gov/public-employee-benefits** *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 *2017 Premium Surcharge Help Sheet*.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

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 Program 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 within PEBB's enrollment timelines to enroll a spouse or state-registered domestic partner.***

Relationship to subscriber
- ❑ Spouse: date of marriage _____
- ❑ 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
				❑ M ❑ F

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

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 the spouse or state-registered domestic partner'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 Part D (prescription-drug coverage) of Medicare? 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 *2017 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 2017 Premium Surcharge Help Sheet *in the* 2017 Retiree Enrollment Guide *or at* **www.hca.wa.gov/public-employee-benefits** *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 *2017 Premium Surcharge Help Sheet* and completed the *2017 Spousal Plan Calculator.*
- ❑ **NO, I am not subject to the $50 surcharge.** I used the *2017 Premium Surcharge Help Sheet* (and, if needed, completed the *2017 Spousal Plan Calculator* online.)

  Which questions (if any) on the *2017 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
- ❑ PEBB Program to determine. I am completing and submitting the *2017 Spousal Plan Calculator* found at **www.hca.wa.gov/public-employee-benefits**.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

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 Program 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 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	*(Check only if age 26 or older)* Disabled? ☐ 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 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 Part D (prescription-drug coverage) of Medicare? 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 *2017 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	*(Check only if age 26 or older)* Disabled? ☐ 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 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 Part D (prescription-drug coverage) of Medicare? 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 *2017 Premium Surcharge Help Sheet*.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 4: Changes to an Existing Account

Are you making changes to an existing 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, 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 *Extended Dependent Certification* form available at **www.hca.wa.gov/public-employee-benefits**.

❑ Child becoming eligible as a dependent with a disability. Also complete *Certification of Dependent With a Disability* form available at **www.hca.wa.gov/public-employee-benefits.**

❑ 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 dependent of the subscriber.

❑ Subscriber or dependent becoming entitled to coverage 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 cancelling 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)

2017 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

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.

Group Health Cooperative
- ❑ Group Health Classic
- ❑ Group Health Medicare Plan[1,2]
- ❑ Group Health SoundChoice[3]
- ❑ Group Health Value

Group Health Options Inc.
- ❑ Group Health Consumer-Directed Health Plan[4]

Kaiser Foundation Health Plan of the Northwest
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan[4]
- ❑ Kaiser Permanente 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[6] (select one network below)
- ❑ UMP Plus-Puget Sound High Value Network[6]
- ❑ UMP Plus-UW Medicine Accountable Care Network[6]

[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 family members not enrolled in Medicare Part A and Part B, also select Group Health Classic, SoundChoice, or Value for these family members.**

[3] **This plan is available only if at least one covered family member is not enrolled in Medicare Part A and Part B. Family members enrolled in Medicare Part A and Part B will be enrolled in Group Health's Medicare Plan.**

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

Section 6: Dental Plan Selection *Check only one. **You must enroll in medical coverage to enroll in dental.***

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 coverage as allowed under PEBB Program rules. However, you may change retiree dental plans within those two years during the annual PEBB Program open enrollment 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

❑ Uniform Dental Plan, administered by **Delta Dental of Washington (Group #3000)**
You can choose any dental provider and change providers at any time.

Managed-Care Plans

❑ DeltaCare, administered by **Delta Dental of Washington (Group #3100)**
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)

Subscriber's last name	First name	Middle initial	Social Security number

Section 7: Retiree Term Life Insurance Election

Retiree term life insurance is available only if you receive PEBB employee life insurance. 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, please complete the *MetLife Enrollment/Change Form for Retiree Plan*, including the beneficiary designation, and sign and date the form. Return that form with this *Retiree Coverage Election/Change* form to the PEBB Program at the address on page 8 of this form.

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

If you wish for your premium for the retiree term life insurance to be deducted from your Department of Retirement Systems (DRS) 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 surcharges?	**How to make the first payment**
❑ **Pension Deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), including life insurance if selected, 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 premiums (if elected) 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 premiums (if elected) before I will be enrolled** and will complete and submit the *Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. I will pay my monthly premium and any applicable surcharges as invoiced 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. If you also wish to pay by EDS for your retiree term life insurance, contact MetLife at 1-866-7139.	If you select one of the options at the left for your medical and dental premiums, 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)

2017 Retiree Coverage Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

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 Program 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 Program benefits.

If I send payment, this does not mean I will be automatically enrolled in PEBB Program 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 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 Program 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 if I chose DeltaCare, I called 1-800-650-1583 to verify my dentist is a DeltaCare contracted dentist.

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 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 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 the DRS to better serve me.

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/public-employee-benefits**.

Subscriber's signature _____ **Date** _____

Be sure to sign and date this form. 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/public-employee-benefits** or call us at 1-800-200-1004

2017 PEBB Program Medical Contractors

Group Health Cooperative
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc.
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 the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 711

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 TTY 711

2017 PEBB Program Dental Contractors

DeltaCare, administered by Delta Dental of Washington
9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan,
administered by Delta Dental of Washington
9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

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

2017 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