2023 SEBB Continuation Coverage (COBRA) Election/Change

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

We must receive this form **no later than 60 days** from the date your SEBB health plan coverage ends or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent to you, whichever is later.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends. We will not enroll you until we receive your first payment. If HCA does not receive your first payment during this 45-day timeframe, you will not be enrolled and you will lose your rights for SEBB Continuation Coverage (COBRA). Premiums and applicable premium surcharges are due from the date your other coverage ended.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted. Therefore, you must complete the entire form, including the dependent section for any children you want to continue to cover.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in black ink and use all capital, block lettering in the spaces provided. Example: J O H N

All forms and documents are available at **hca.wa.gov/sebb-continuation** under *Forms & publications*, or by calling the SEBB Program at 1-800-200-1004 (TRS: 711).

⚠ Remember to read and sign Section 7. To add or remove children, complete Section 8 on page 13.

School employee information only

Last name

First name

Social Security number

Date SEBB health plan coverage ended

1 Subscriber

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

[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**

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP/Postal code

County

⚠ If you move, you must report your new address to the SEBB Program **no later than 60 days** after you move. You can report it by using this form, by sending a written request by mail or secure message (see the "Form return" section on page 11), or by calling 1-800-200-1004 (TRS: 711).

Are you or any eligible dependents already enrolled in SEBB insurance coverage under another account?

☐ Yes ☐ No

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Termination date

If terminating coverage, include reason:

⚠ You may elect to continue coverage you were enrolled in on the day your SEBB health plan coverage ended. If you have life insurance and wish to port or convert, call MetLife at 1-833-854-9624.

If you are enrolled in a Medical Flexible Spending Arrangement (FSA) or Limited Purpose FSA and would like to continue it, call Navia Benefit Solutions at 1-800-669-3539. Navia must receive your request **no later than 60 days** from the date your SEBB health plan coverage ended, or from the postmark date on the *Navia COBRA election notice* sent to you, whichever is later.

⚠ If you terminate all coverage, you will not be eligible to enroll again in SEBB Continuation Coverage unless you regain eligibility.

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Are you covered by another group medical plan?

☐ Yes ☐ No If Yes, effective date

Are you covered by another group dental plan?

☐ Yes ☐ No If Yes, effective date

Do you receive Social Security Disability?

☐ Yes ☐ No If Yes, effective date

⚠ If **Yes**, attach a copy of your Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Are you enrolled in Medicare Part A or Part B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on your Medicare card:

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on your Medicare card:

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The SEBB Program requires a $25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your SEBB medical plan 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 or your dependent's health, see more information in the SEBB Program Administrative Policy 91-1 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 *SEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/sebb-continuation** under *Forms & publications*. To change your attestation, use the *SEBB Premium Surcharge Attestation Change* form.

Does the tobacco use premium surcharge apply to you?

☐ **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 the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or SRDP you wish to add or remove from medical, dental, or vision coverage. State-registered domestic partner is defined in WAC 182-31-020. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. Your spouse or SRDP cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time. A health plan change is not allowed when adding an SRDP if they are not a tax dependent. To add children, complete Section 8 at the end of this form.

Relationship to subscriber. Check one.

☐ Spouse: Date of marriage

☐ SRDP: Date registered

⚠ If enrolling an SRDP, attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. You must also provide proof of their eligibility within the SEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/sebb-continuation**.

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)

Address line 2

City

State

ZIP/Postal code

County

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Termination date

If terminating coverage, include reason:

⚠ If removing a spouse due to divorce, attach a copy of the divorce decree. If removing an SRDP due to a dissolution, attach a copy of the dissolution of state-registered domestic partnership.

[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

Is this person covered by another group medical plan?

☐ Yes ☐ No If Yes, effective date

Is this person covered by another group dental plan?

☐ Yes ☐ No If Yes, effective date

Does this person receive Social Security Disability?

☐ Yes ☐ No If Yes, effective date

⚠ If **Yes**, attach a copy of their Social Security Disability Award letter. Write your last name and last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part A or Part B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. If you check Yes or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium. See the *SEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/sebb-continuation** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you?

☐ **Yes**, I am subject to the $25 premium surcharge. My spouse or SRDP 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. My spouse or SRDP has not used tobacco products in the past two months or has enrolled in or accessed the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Spouse or state-registered domestic partner coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The SEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you enroll your spouse or SRDP in SEBB medical coverage, and they have chosen not to enroll in another employer-based group medical coverage that is comparable to the Public Employees Benefits Board (PEBB) Program Uniform Medical Plan (UMP) Classic. See the *SEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. If you check Yes or leave this section blank, you will be charged the $50 premium surcharge.

Does the spouse or SRDP coverage 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*.

⚠ The *SEBB Premium Surcharge Attestation Help Sheet* and *SEBB Spousal Plan Calculator* are available at **hca.wa.gov/sebb-continuation** under *Forms & publications.*

☐ **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 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

☐ The SEBB Program to help determine if premium surcharge applies. I used the SEBB Premium Surcharge Attestation Help Sheet and am submitting a printed *SEBB Spousal Plan Calculator*. The SEBB Program will use these to help determine whether my spouse's or SRDP's employer-based group medical is comparable to UMP Classic and whether I am subject to this premium surcharge.

Subscriber's last name

Social Security number

3 Changes to an existing account

Are you making changes to an existing account?

☐ Yes, If Yes, check all changes that apply in the sections below.

Date of event/change

☐ No If No, continue to Section 4.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for you or your enrolled dependents

☐ Terminate vision coverage for you or your enrolled dependents

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

Street address

Address line 2

City State ZIP/Postal code

Changes you can make during annual open enrollment

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

☐ Add dependents

☐ Remove dependents

☐ Add or change medical plan

☐ Add or change dental plan

☐ Add or change vision plan

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

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

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

To enroll a newborn or child whom you, the subscriber, has adopted or has assumed a legal responsibility for support ahead of adoption, you should notify the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth, adoption, or the date the legal responsibility for support is assumed ahead of adoption.

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.

Check the box next to the matching events below.

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

The following events allow a subscriber to add dependents or change medical, dental, or vision plans:

- Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution under their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects the dependent's eligibility or their dependent's eligibility for their employer contribution under their employer-based group health plan.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- Subscriber or dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicare.
- Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *SEBB Extended Dependent Certification* and *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes, available at **hca.wa.gov/sebb-continuation**.
- Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. You must also submit a *SEBB Declaration of Tax Status* if adding a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes.

Subscriber's last name

Social Security number

The following events allow a subscriber to add dependents:

- ☐ Subscriber or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment.
- ☐ A dependent moves from another country to within the United States, or from the United States to another country, and that change resulted in the dependent losing their health insurance.

The following events allow a subscriber to change medical plan, dental plan, or vision plan:

- ☐ Subscriber or dependent has a change in residence that affects health plan availability.
- ☐ Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- ☐ Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program).
- ☐ Subscriber has a change in employment from a SEBB organization to a school district that crosses county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available.

4 Medical plan selection

Kaiser Foundation Health Plan of the Northwest[1] (Kaiser Permanente NW)

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

Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)

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

Kaiser Foundation Health Plan of Washington, Options, Inc. (Kaiser Permanente WA Options)

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

Premera Blue Cross

- ☐ Premera High PPO
- ☐ Premera Standard PPO
- ☐ Premera HMO

Uniform Medical Plan, administered by Regence BlueShield and Washington State Rx Services

- ☐ UMP Achieve 1
- ☐ UMP Achieve 2
- ☐ UMP High Deductible
- ☐ UMP Plus–Puget Sound High Value Network
- ☐ UMP Plus–UW Medicine Accountable Care Network

⚠ Call the medical plans you are interested in to make sure your provider is in the network. Contact the plans for benefits information. Contact information is on page 12 of this form. These plans have specific service areas based on your county of residence. See HCA's website **hca.wa.gov/sebb-continuation** for plans available to you.

If you move out of the medical plan's service area, you may need to change plans. You must report your new address to the SEBB Program **no later than 60 days** after you move using this form, by calling 1-800-200-1004 (TRS: 711), or by sending a written request to the address listed on page 11.

[1] *Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.*

Subscriber's last name

Social Security number

5 Dental plan selection

Choose one dental plan. Before you enroll, make sure the provider you want to use accepts the specific plan and group you choose.

Preferred Provider Organization (PPO)

☐ **Uniform Dental Plan** (Group #09600)
You can choose any dental provider and change providers at any time. Your out-of-pocket costs will be less if you use a preferred provider.

Managed-care plans (limited network)

☐ **DeltaCare** (Group #09601)
You must select a primary care dentist in the DeltaCare network.

☐ **Willamette Dental Group of Washington** (Group WA 733), administered by Willamette Dental of Washington, Inc.
You will select and receive care from a primary care dental provider in the Willamette Dental Group network.

6 Vision plan selection

Choose one vision plan. Before you enroll, make sure the provider you want to use accepts the specific plan you choose.

☐ **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

I have received and read the *SEBB Continuation Coverage Election Notice*, including any appendices. 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 timeline 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 may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of SEBB insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in SEBB insurance coverage. The SEBB Program will verify eligibility for me and my dependents. If we do not qualify, I will receive a refund.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or state-registered domestic partner (SRDP) coverage premium surcharge in addition to my monthly medical 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 the SEBB Program will direct a portion of my monthly premium 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 Program rules and policies. Failure to comply with applicable deadlines and SEBB Program rules and policies may result in my benefits selection being rejected.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted to the SEBB Program.

Sign, date, and keep a copy for your records.

Subscriber's signature

Date (mm/dd/yyyy)

Form return

Submit form and documentation using one of the methods below:

Mail to:

Washington State Health Care Authority
PO Box 42720
Olympia, WA 98504-2720

Fax to:

360-725-0771

If payment is enclosed, make check payable to Health Care Authority and mail to:

Washington State Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Secure message:

Send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

⚠ Continue to section 8 to add or remove children.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call the SEBB Program at 1-800-200-1004 (TRS: 711).

HCA's Privacy notice: HCA will keep your information private as allowed by law. To see our Privacy Notice, go to the HCA website at **hca.wa.gov/sebb-continuation**.

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

SEBB Program contractors

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

Medical

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St.,
Suite 100
Portland, OR 97232
1-800-813-2000 (TRS: 711)

Kaiser Foundation Health Plan of Washington
1300 SW 27th Street
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc.
1300 SW 27th Street
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

Premera Blue Cross
High PPO and Standard PPO
PO Box 327
Seattle, WA 98111
1-800-807-7310
TTY: 1-800-842-5357 (TRS: 711)

Premera HMO
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)
PO Box 2998
Tacoma, WA 98401
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
1-888-361-1611 (TRS: 711)

Dental

DeltaCare
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-537-3460
TTY: 1-800-833-6384

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

Vision

Davis Vision
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
1-877-377-9353
TTY: 1-800-523-2847

EyeMed Vision Care
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
1-833-854-9624
TTY: 1-800-428-4833

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

8 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.

If enrolling a state-registered domestic partner's child, extended dependent, or other nonqualified tax dependent, attach a *Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP's child if they are not a tax dependent.

If enrolling an extended dependent, attach an *Extended Dependent Certification* form, a valid court order showing legal custody or guardianship.

If enrolling a child with a disability age 26 or older, also attach a *Certification of Child with a Disability*.

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (court order needed)
- Child with a disability age 26 or older

⚠ **Dependents cannot be enrolled in two SEBB medical, dental, or vision plans at the same time.**

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Continue coverage (Select all that apply.)
Medical Dental Vision

Add coverage (Select all that apply.)
Medical Dental Vision

Terminate coverage (Select all that apply.)
Medical Dental Vision

Termination date

If terminating 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**

2023 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Is this person covered by another group medical plan?

Yes No If Yes, effective date

Is this person covered by another group dental plan?

Yes No If Yes, effective date

Does this person receive Social Security Disability?

Yes No If Yes, effective date

⚠ If **Yes**, attach a copy of their Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part A and Part B?

Part A (hospital)

Yes No If Yes, enter effective dates shown on their Medicare card:

Part B (medical)

Yes No If Yes, enter effective dates shown on their Medicare card:

Tobacco use premium surcharge

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

Does the tobacco use premium surcharge apply to you?

Yes, I am subject to the $25 premium surcharge. My 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. My dependent has not used tobacco products in the past two months or has enrolled in or accessed the tobacco cessation resources noted in the *SEBB Premium Surcharge Attestation Help Sheet*.

⚠ If adding two or more dependents, copy pages 13 to 14 and attach to this form.