Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

A

2023 PEBB Retiree Election Form (form A)

Complete this form to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage. If you wish to make a change to an existing retiree account, please use the *PEBB Retiree Change Form* (form E). All forms and documents mentioned and a self-paced tutorial about how to complete this form are available on HCA's website at **hca.wa.gov/pebb-retirees**.

Remember to read and sign Section 7. To enroll children, fill out Section 9. This form replaces all retiree enrollment/change forms submitted in the past.

Type or print in dark ink using all capital lettering in the spaces provided. Inaccurate, incomplete, or illegible information may delay coverage.

Example: J O H N

Required General information

Retiree, employee, or school employee information only

If you are a surviving spouse, state-registered domestic partner (defined in WAC 182-12-109), or dependent, provide the deceased employee's or retiree's information below. Provide your personal information in Section 1.

Retiree, employee, or school employee last name

Social Security number

Retirement plan

Retirement date (or separation date for Plan 3 or higher-education retirement plans)

Check one:

Enrolling: I am a new retiree or a surviving dependent requesting to enroll in coverage.

Deferring: I am a new retiree or a surviving dependent deferring (postponing) my coverage. Select your reason for deferral in Section 1. See the *PEBB Retiree Enrollment Guide* for details about deferring.

Enrolling after deferring: Date other qualifying medical coverage ended

With this form, you must provide proof of your continuous enrollment in other qualifying coverages since your date of deferral.

Separating: Eligible under Plan 3 or a higher-education retirement plan, separating as of

For new nonrepresented employees of a Washington State educational service district who are retiring:

Educational Service District (ESD)

When does your current health plan coverage through your ESD, COBRA, or continuation coverage end?

Note: If you are applying to enroll in or defer retiree insurance coverage after your COBRA or continuation coverage ends, you must submit proof of your continuous health coverage with this form.

2023 PEBB Retiree Election Form

Subscriber's last name

Social Security number

1 Subscriber

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

Are you enrolled in Medicare Part A or Part B?

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

Medicare number

If Yes, proof is required. Attach a copy of your entire entitlement letter or a copy of your Medicare card to this form if we don't already have a copy. If you are eligible for Medicare, you must enroll and stay enrolled in both Part A and Part B to keep PEBB retiree health plan coverage.

I am in the process of enrolling in Medicare Part A and Part B. I will submit proof after I receive my entitlement letter or Medicare card. You will not be enrolled until your proof of Medicare is received.

Are you enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If Yes, you may enroll only in Premera Blue Cross Medicare Supplement Plan G. If you want to enroll in any other PEBB medical plan, you must disenroll from your Part D plan.

[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.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Are you enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

I wish to:

Enroll: (Check all that apply.)

Medical only Medical and dental Retiree term life insurance

Defer: Defer (postpone) my coverage. Except as stated below, this defers coverage for all eligible dependents.

Deferral date:

Enroll after deferring coverage: You will need to provide proof of continuous enrollment in one or more qualifying coverages (with start and end dates). A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each qualifying coverages during the deferral period.

Date other qualifying coverage ended:

If deferring or enrolling after deferring, check the box(es) below that apply to you.

Enrolled as a dependent in a health plan sponsored by the PEBB Program, a Washington State educational service district, or a School Employees Benefits Board (SEBB) Program. This includes coverage under COBRA or continuation coverage.

Enrolled in employer-based group medical as an employee or employee's dependent, including medical insurance continued under COBRA or continuation coverage. This does not include an employer's retiree coverage.

Enrolled in medical coverage as a retiree or dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in a PEBB retiree health plan.

Enrolled in a Medicaid program that provides creditable coverage and in Medicare Part A and Part B. You may continue to cover eligible dependents who are not eligible for creditable coverage under Medicaid.

Enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). You have a one-time opportunity to enroll in a PEBB retiree health plan.

Non-Medicare subscribers 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 a PEBB retiree health plan.

⚠ The premium surcharges, if applicable, only apply to subscribers who are **not** enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The PEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the PEBB Program Administrative Policy 91-1 on HCA's website at **hca.wa.gov/pebb-rules**.

If you check Yes or do not check any boxes below, you will be charged the $25 premium surcharge. See the *PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

No, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

Yes, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.

No, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB 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 cover. SRDP is defined in Washington Administrative Code 182-12-109. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time. To enroll children, please complete Section 9 at the end of this form.

Relationship to subscriber

☐ Spouse: date of marriage

⚠ Non-Medicare subscribers: If enrolling a spouse, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. A list of documents we will accept to prove their eligibility is available on HCA's website at **hca.wa.gov/pebb-retirees**.

☐ SRDP: date registered

⚠ All subscribers: If enrolling an SRDP, attach a *PEBB 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 PEBB 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/pebb-retirees**.

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber's)

Address line 2

City

State

ZIP/Postal code

County

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

Part A (hospital) ☐ Yes ☐ No If Yes, enter effective date from Medicare card:

Part B (medical) ☐ Yes ☐ No If Yes, enter effective date from Medicare card:

Medicare number

If Yes, proof is required. Attach a copy of their entire entitlement letter or a copy of their Medicare card to this form if we don't already have a copy. Write the subscriber's full name and the last four digits of their Social Security number on the copy. If your dependent is eligible for Medicare, they must enroll and stay enrolled in Part A and Part B to keep PEBB retiree health plan coverage.

[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.wa.gov/gender-x**.

Subscriber's last name

Social Security number

☐ They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their entitlement letter or Medicare card. Your dependent will not be enrolled until their proof of Medicare is received.

Is this person enrolled in Medicare Part D (prescription drug coverage)?

☐ Yes ☐ No If Yes, effective date:

If Yes, they may enroll only in Premera Blue Cross Medicare Supplement Plan G. If they want to enroll in any other PEBB medical plan, they must disenroll from the Part D plan.

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No If Yes, effective date:

⚠ The premium surcharges, if applicable, only apply to subscribers who are **not** enrolled in Medicare Part A and Part B.

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 $25 premium surcharge. See the *PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

☐ **No,** the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **Yes,** I am subject to the $25 premium surcharge. This person has used tobacco products in the past two months.

☐ **No,** I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*.

Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan Classic.

⚠ If you check **Yes** or do not check any boxes in this section, you will be charged the $50 premium surcharge. See the *2023 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

Does the spouse or SRDP coverage premium surcharge apply to you? Check one:

☐ **No,** the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **Yes,** I am subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *PEBB Spousal Plan Calculator* online.

☐ **No,** I am not subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *PEBB Spousal Plan Calculator* online. Which questions on the *PEBB 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 PEBB Program to help determine if the premium surcharge applies. I used the *PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *PEBB Spousal Plan Calculator*.

Subscriber's last name

Social Security number

3 Medical plan selection

Contact the plans with questions about benefits and providers. Contact information is on page 10 of this form.

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

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2,5]
- ☐ Kaiser Permanente NW Senior Advantage[3]

Kaiser Foundation Health Plan of Washington[1] (Kaiser Permanente WA)

- ☐ Kaiser Permanente WA Classic[6]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA Medicare Plan[3,4]
- ☐ Kaiser Permanente WA SoundChoice[6]
- ☐ Kaiser Permanente WA Value[6]

Premera Blue Cross

- ☐ Medicare Supplement Plan G[7]

Uniform Medical Plan (UMP), administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Select[5]
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus–Puget Sound High Value Network[1, 5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[1, 5]

UnitedHealthcare Medicare Advantage Prescription Drug

- ☐ UnitedHealthcare PEBB Balance[8]
- ☐ UnitedHealthcare PEBB Complete[8]

1. These plans have specific service areas. If you move out of the service area, you must change your plan. Otherwise, you will have limited access to network providers and covered services. You must notify the PEBB Program **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. These Medicare plans are available only in certain counties. See "Medical plans available by county" at **hca.wa.gov/pebb-retirees**.
4. If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.
5. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.
6. Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.
7. Also submit Form B to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.
8. These plans are only available to Medicare members. Enrollment in these plans may not be retroactive. If the required forms are received after the date PEBB retiree insurance coverage is to begin, you and your enrolled dependents will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare coverage begins. Any non-Medicare members on your account will continue to be enrolled in UMP Classic.

Subscriber's last name

Social Security number

4 Dental plan selection

You must enroll in medical coverage to enroll in dental. Before you enroll, call the dental plan to make sure your provider accepts the specific plan and plan group you choose. Their contact information is on page 11 of this form.

Preferred Provider Organization (PPO)

☐ **Uniform Dental Plan** (Group #3000). You can choose any dental provider and change providers at any time.

Managed-Care Plans (limited network)

☐ **DeltaCare** (Group #3100). You must select a primary care dentist in the DeltaCare network.

☐ **Willamette Dental Group of Washington** (Group WA82), administered by Willamette Dental of Washington, Inc. You will select and receive services from a provider in the Willamette Dental Group network.

5 Retiree term life insurance

Retiree term life insurance is available only if you received PEBB life insurance as an employee or SEBB life insurance as a school employee. You are not eligible for the retiree term life insurance plan if you qualify for a waiver of premium benefit under the PEBB employee life insurance or SEBB employee life insurance plans until that waiver of premium benefit ends. To apply for retiree term life insurance, submit the *MetLife Enrollment/Change Form for Retiree Plan* (including 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.

6 Payment

You have three payment options: pension deduction, invoicing, and electronic debit service. In most cases, you must make your first payment by check before we can enroll you.

How to make the first payment

If you select electronic debit service (EDS) or invoicing below, you must make your first payment by check. Your first premium payment and applicable premium surcharges are due **no later than 45 days** after your 60-day election period ends. We will not enroll you in coverage until we receive your first payment. If you miss this deadline, you may lose your right to enroll in PEBB retiree insurance coverage. Make your check payable to Health Care Authority. Send it (and your EDS form, if you choose that option) to:

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

If you select pension deduction below, the PEBB Program will send you an invoice if the first payment is needed. Due to timing issues with the Department of Retirement Systems, a first payment may be required for premiums and applicable premium surcharges that were not deducted from your pension. If you receive an invoice, you must pay by check until your pension deduction is set up.

You cannot have a gap in coverage. Premiums are due back to the first of the month in which your PEBB retiree insurance coverage was effective. Premiums and applicable premium 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.

Subscriber's last name

Social Security number

How would you like to pay?

Electronic debit service (EDS): I will pay my monthly medical and dental premiums (if elected) and applicable premium surcharges by EDS. I will submit the *PEBB Electronic Debit Service (EDS) Agreement* available in the *Retiree Enrollment Guide* and on HCA's website at **hca.wa.gov/pebb-retirees** under *Forms & publications*. I understand I must pay by check until I am notified of my EDS effective date, and that I must make my first payment before I will be enrolled. 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, call MetLife at 1-866-548-7139.

Pension deduction: I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and applicable premium surcharges I am required to pay from my retirement pension. I understand that 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.

Invoicing: I will pay my medical and dental premiums (if elected) and applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. I understand that I must make my first payment before I will be enrolled.

7 Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB 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 PEBB health plan coverage 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 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 PEBB insurance 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 dependents. If we do not qualify, I will receive a refund of premium payments.

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

I understand if I enroll in PEBB retiree dental, it is my responsibility to call the plan (not my provider) to verify my dentist is covered by the dental plan network I selected.

I understand if I or any enrolled dependent are eligible for Medicare Part A and Part B, we must enroll and stay enrolled in Part A and Part B.

If I choose to defer medical/dental for myself, I cannot enroll my eligible dependents. I understand I can enroll or reenroll **no later than 60 days** after losing other qualifying medical coverage or during the PEBB Program's annual open enrollment as long as I maintain and provide proof of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, as well as between each enrollment in qualifying coverages during the deferral period. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or no later than the last day of the PEBB Program's annual open enrollment.

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 dependents must complete the *PEBB Retiree Election Form* (form A) to enroll or defer enrollment in PEBB retiree insurance coverage. The PEBB Program must receive the form no later than 60 days after my death.

If I am electing to enroll in a Kaiser Medicare Advantage (MA) or UnitedHealthcare Medicare Advantage Prescription

Subscriber's last name

Social Security number

Drug (MAPD) plan, I certify that I have read and understand the Statement of Understanding in Section 8. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage contract. I understand that enrollment in a Kaiser MA or UnitedHealthcare MAPD plan may not be retroactive. If I elect to enroll in a Kaiser MA plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser plan during the gap month(s) prior to when Kaiser MA coverage begins. If I elect to enroll in a UnitedHealthcare MAPD plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare MAPD plan begins. **This form cannot be signed more than 90 days before the effective date of this coverage**. (See Statement of Understanding in Section 8 for coverage effective date.)

This form replaces all election or change forms previously submitted to the PEBB Program. If I am a retiree or survivor 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 Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my insurance coverage selections being rejected or defaulted.

Please sign, date, and keep a copy for your records.

Subscriber signature

Date

Spouse or SRDP signature (only if enrolling in a Medicare Advantage or Medicare Advantage Prescription Drug health plan)

Date

Form return

Submit form and documentation using one of the methods below:

Mail to:
Washington State Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

Fax to: 360-725-0771
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.

HCA is committed to providing equal access to our services. If you need an accommodation, please call the PEBB Program at 1-800-200-1004.

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

Subscriber's last name

Social Security number

8 Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected in Section 3 of this form, as long as this form is signed prior to the effective date, 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 when required 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 day PEBB insurance begins, or 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 they may begin using the plan services as of the effective date of enrollment.

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

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

Subscriber's last name

Social Security number

PEBB Program contractors

Do not send forms to addresses below. They are 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)
Medicare members: 1-877-221-8221 (TRS: 711)

Kaiser Foundation Health Plan of Washington
1300 SW 27th Street
Renton, WA 98057
1-866-648-1928
TTY: 1-800-833-6388
Medicare Advantage: 1-888-901-4600

Premera Blue Cross
PO Box 327, MS 295
Seattle, WA 98111
1-800-817-3049
TTY: 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield (for medical benefit questions)
PO Box 2998
Tacoma, WA 98401
1-888-849-3681 (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)

UnitedHealthcare
Customer Service Department
PO Box 30770
Salt Lake City, UT 84130
1-855-873-3268

Dental

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

Uniform Dental Plan
400 Fairview N, Suite 800
Seattle, WA 98109
1-800-537-3406
TTY: 1-800-833-6384

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

Life insurance

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

Subscriber's last name

Social Security number

9 Dependents

List eligible dependents you wish to enroll. Children must be eligible under PEBB 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. Visit HCA's website at **hca.wa.gov/pebb-retirees** for eligibility information.

Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.

Subscribers who are not enrolled in Medicare Part A and Part B must provide proof of eligibility for each dependent within the PEBB Program's enrollment timelines or the dependent will not be enrolled. Timelines and a list of documents we will accept to prove dependent eligibility are available on HCA's website at **hca.wa.gov/pebb-retirees**.

If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, also attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

If enrolling an extended dependent, also attach a *PEBB Extended Dependent Certification*.

If enrolling a child with a disability age 26 or older, submit a *PEBB Certification of a Child with a Disability* as instructed on the form.

Relationship to subscriber

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

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

[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.wa.gov/gender-x**.

2023 PEBB Retiree Election Form

Subscriber's last name

Social Security number

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

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

Medicare number

If Yes, proof is required. Attach a copy of their entire entitlement letter or a copy of their Medicare card to this form if we don't already have a copy. Write the subscriber's full name and the last four digits of their Social Security number on the copy. If your dependent is eligible for Medicare, they must enroll and stay enrolled in Part A and Part B to keep PEBB retiree health plan coverage.

They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their entitlement letter or Medicare card. Your dependent will not be enrolled until their proof of Medicare is received.

Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If Yes, they may enroll only in Premera Blue Cross Medicare Supplement Plan G. If they want to enroll in any other PEBB medical plan, they must disenroll from the Part D plan.

Is this person enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

The premium surcharges, if applicable, only apply to subscribers who are **not** enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling a 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 premium surcharge. See the *PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

No, the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

Yes, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.

No, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet.*