Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Employee Enrollment/Change

Clear form

Type or print clearly in dark ink, use only capital block lettering inside the boxes as shown in the example. Inaccurate, incomplete, or illegible information may delay coverage.

Remember to sign and date page 8. To add dependents, fill out Section 7 starting on page 9. This form replaces all *Employee Enrollment/Change* forms previously submitted.

Follow example to fill in form: J O H N

Section 1 Subscriber information

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy) / /

Social Security number - -

Sex ☐ M ☐ F

Phone number - -

Work phone number - -

Street address

Address line 2

City

State

ZIP Code -

County of residence

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP Code -

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

☐ **Yes**
If yes, please contact your personnel, payroll, or benefits office for assistance.

☐ **No**

Medical coverage

☐ **Cover**

☐ **Waive** If waiving, see Section 6.
Note: If you waive coverage, you cannot enroll your eligible dependents in medical.

Dental coverage

✓ **Cover**
(Dental may not be waived.)

This section to be completed by employer.

Agency name:

Agency/subagency number:

Eligibility date: / /

Insurance effective date: / /

Subscriber's last name

Subscriber's Social Security number

Tobacco use premium surcharge

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 you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-employee** for instructions on how to respond.

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

☐ **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, indicate the date your tobacco use changed.
Date of change (mm/dd/yyyy)

☐ **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 *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Subscriber's Social Security number

Section 2 Spouse or state-registered domestic partner

List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-109, you wish to cover or remove from coverage.

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

If adding a spouse or state-registered domestic partner, you must also provide proof of dependent eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled.

A list of documents we will accept to verify the dependent's eligibility is available at **hca.wa.gov/pebb-employee**.

Relationship to subscriber

If adding a state-registered domestic partner, please also attach a completed *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

☐ Spouse: date of marriage / /

☐ State-registered domestic partner: date registered / /

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy) / /

Social Security number –

Sex ☐ M ☐ F

Street address

Address line 2

City

State

ZIP Code –

Medical coverage

☐ Cover

☐ Remove from medical

Reason:

Dental coverage

☐ Cover

☐ Remove from dental

Reason:

Tobacco use premium surcharge

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Check one.

☐ **Yes, I am subject to the $25 premium surcharge.** This person has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the date their tobacco use changed.
Date of change (mm/dd/yyyy) / /

☐ **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 *2020 PEBB Premium Surcharge Attestation Help Sheet*.

2020 PEBB Employee Enrollment/Change

Subscriber's last name

Subscriber's Social Security number

Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical, and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. If you check **Yes** below or leave this section blank, you will be charged the monthly $50 premium surcharge. If you check **No**, identify the questions you checked **No** to.

Does the spouse or state-registered domestic partner coverage premium surcharge apply to you? Check one.

☐ **Yes**, I am subject to the $50 premium surcharge. I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 PEBB Spousal Plan Calculator* online.

The *2020 PEBB Premium Surcharge Attestation Help Sheet* and the *2020 PEBB Spousal Plan Calculator* are available at **hca.wa.gov/pebb-employee**. To change your previous attestation, use the *2020 PEBB Premium Surcharge Attestation Change Form*.

☐ **No**, I am not subject to the $50 premium surcharge.
I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *2020 PEBB Spousal Plan Calculator* online. If **No**, which questions on the *2020 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

☐ **Employer to determine** if premium surcharge applies.
I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *2020 PEBB Spousal Plan Calculator*. My employer will use these to determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to PEBB's UMP Classic and if I am subject to the premium surcharge.

Note: Do not send forms to the addresses below. They are only for your reference.

2020 PEBB Program medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388

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

2020 PEBB Program dental contractors

DeltaCare, *administered by Delta Dental of Washington*
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-650-1583

Uniform Dental Plan, *administered by Delta Dental of Washington*
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124
1-855-4DENTAL (1-855-433-6825)

Subscriber's last name

Subscriber's Social Security number

Section 3 Medical plan selection *Check only one.*

If you are eligible for the employer contribution toward PEBB benefits but do not waive or enroll in PEBB Program medical coverage, you will be enrolled by default as a single subscriber in Uniform Medical Plan (UMP) Classic. Your dependents will not be enrolled. You will be charged a monthly $104 premium for medical coverage as well as a $25-per-account monthly tobacco use premium surcharge.

Kaiser Foundation Health Plan of the Northwest[1]

- ☐ Kaiser Permanente NW[2] Classic
- ☐ Kaiser Permanente NW[2] Consumer-Directed Health Plan

Kaiser Foundation Health Plan of Washington1

- ☐ Kaiser Permanente WA Classic
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan
- ☐ Kaiser Permanente WA SoundChoice[3]
- ☐ Kaiser Permanente WA Value

Uniform Medical Plan, administered by Regence BlueShield

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

Contact the plans for benefit and provider information. Their contact information is located on page 4.

1. These plans have a specific service area. 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 report your new address to your personnel, payroll, or benefits office and request a plan change **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
3. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before you visit.

Section 4 Dental plan selection *Check only one.*

Preferred Provider Organization (PPO)

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

Managed-Care Plans (limited network)

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

☐ **Willamette Dental of Washington, Inc.** (Group WA82), administered by Willamette Dental Group
You must receive services from a Willamette Dental Group plan provider. Call Willamette Dental Group at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

Subscriber's last name

Subscriber's Social Security number

Section 5 Account changes and special open enrollment

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 6 (Signature) on page 8.

Changes you can make anytime

If you have a name or address change, contact your personnel, payroll, or benefits office.

Give date of event/change / /

☐ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB benefits). Your personnel, payroll, or benefits office must receive this form and proof of the event **no later than 60 days** after the last day of the month the dependent loses eligibility for health plan coverage. If applicable, provide former dependent's new address:

Former dependent's new street address

Former dependent's city

State

ZIP Code

Changes you can make during the PEBB Program's annual open enrollment (November 1-30)

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

☐ Add dependent(s)

☐ Change dental plan

☐ Remove dependent(s)

☐ Enroll after waiving medical coverage

☐ Change medical plan

☐ Waive medical coverage due to enrollment in other employer-based group medical, a TRICARE plan, or Medicare.

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 change must be allowable under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with a special open enrollment event for the employee, employee's dependent, or both. You are required to provide proof of the event. Your personnel, payroll, or benefits office must receive this form and proof of the event **no later than 60 days** after the event.

Check the box next to the change you are requesting and the corresponding event on the following page. In most cases, the enrollment or change will be effective the first day of the month following the later of the event date or the date this form is received. If that day is the first of the month, the change begins on that day.

☐ Add dependent(s)

☐ Change dental plan

☐ Remove dependent(s)

☐ Enroll after waiving medical coverage

☐ Change medical plan

☐ Waive medical coverage due to enrollment in other employer-based group medical, a TRICARE plan, or Medicare, Medicaid, or a state Children's Health Insurance Program (CHIP).

2020 PEBB Employee Enrollment/Change

Subscriber's last name

Subscriber's Social Security number

– –

The following events allow an employee to add dependent(s), enroll after waiving medical, remove dependent(s), change medical and/or dental plans, and waive medical coverage.

- ☐ Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan.
- ☐ Employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.
- ☐ Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ Marriage, registering a state-registered domestic partner (as defined by Washington Administrative Code 182-12-109), birth, adoption, or assuming a legal obligation for support in anticipation of adoption. Also complete a *2020 PEBB Declaration of Tax Status* form if adding a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

These events allow an employee to add dependent(s), enroll after waiving medical, and change medical and/or dental plans.

- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2020 PEBB Extended Dependent Certification* form.
- ☐ Employee 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.
- ☐ Employee or dependent becomes eligible for a state premium assistance subsidy for PEBB health coverage from Medicaid or a state CHIP.

The following events allow an employee to add dependent(s), enroll after waiving medical, remove dependent(s), and waive medical coverage.

- ☐ Employee or dependent has 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.
- ☐ Employee's dependent moves from outside the United States to live within the United States or moves from inside the United States to live outside the United States, and the move resulted in the dependent losing their health insurance.

The following event allows an employee to add dependents, enroll after waiving, remove dependents, and change medical plans and/or dental plans.

- ☐ A court order that requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee.

The following events allow an employee to change medical and/or dental plans.

- ☐ Employee or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ☐ Employee's or dependent's current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).
- ☐ Employee or dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the employee or their dependent (requires approval by the PEBB Program).
- ☐ Employee or dependent has a change in residence that affects health plan availability.

The following events allow an employee to enroll after waiving medical, and waive medical coverage.

- ☐ Employee or dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.
- ☐ Employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

Subscriber's last name

Subscriber's Social Security number

Section 6 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 plan(s) or premiums paid on my behalf. My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program or my employer 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, denial of PEBB benefits, and loss of my job.

If adding a state-registered domestic partner to my account, I declare that my domestic partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until PEBB verifies the dependent's eligibility. I understand that if I'm applying to add a dependent to my PEBB insurance coverage, I must provide copies of documents that verify the dependent's eligibility within the PEBB Program's enrollment timelines, or the dependent will not be enrolled.

Employees must enroll in PEBB dental, basic life, basic accidental death and dismemberment, and basic long-term disability insurance. Employees that elect to waive PEBB medical when they become newly eligible or during the annual open enrollment, must be enrolled in other employer-based group medical, a TRICARE plan, or Medicare. Employees that elect to waive PEBB medical due to a special open enrollment event must be enrolled in other employer-based group medical, a TRICARE plan, Medicare, Medicaid, or a state Children's Health Insurance Program (CHIP). If I waive medical, I understand I can enroll during the annual open enrollment period or **no later than 60 days** after a special open enrollment event as defined in PEBB Program rules. If I waive medical for myself, I cannot enroll my eligible dependents in medical.

If I am eligible for the employer contribution toward PEBB benefits but do not waive or enroll in PEBB Program medical coverage, I will be enrolled by default as a single subscriber in Uniform Medical Plan (UMP) Classic. My dependents will not be enrolled. I will be charged a monthly $104 premium for medical coverage as well as a $25-per-account monthly tobacco use premium surcharge.

I allow my employer to deduct money from my earnings to pay for insurance coverage and any applicable premium surcharges.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute 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 my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

This form replaces all *Employee Enrollment/Change* forms previously submitted.

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

Subscriber's signature

Date / /

Return completed form and documentation to your personnel, payroll, or benefits office.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact your personnel, payroll, or benefits office.

Subscriber's last name

Subscriber's Social Security number

Section 7 Dependent information

List eligible dependents you wish to cover or remove from coverage including children as defined in WAC 182-12-260(3). Use additional forms for more dependents. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.

If adding a dependent, you must provide proof of dependent eligibility for each dependent within the PEBB Program's enrollment timelines or the dependent will not be enrolled. If adding a state-registered domestic partner's child, also attach a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, also attach a *2020 PEBB Extended Dependent Certification* form.

If enrolling a dependent child with a disability age 26 or older, also attach a *2020 PEBB Certification of a Dependent Child with a Disability* form and return as instructed on the form. Refer to the *2020 PEBB Employee Enrollment Guide* for eligibility information.

A list of documents we will accept to verify dependent eligibility is available at **hca.wa.gov/pebb-employee**.

Relationship to subscriber

☐ Child ☐ Stepchild (not legally adopted) ☐ Extended dependent (attach copy of court order) ☐ Disabled (age 26 or older)

Last name

Suffix

First name

Middle initial

Date of birth (mm/dd/yyyy)

Social Security number

Sex ☐ M ☐ F

Street address

Address line 2

City

State

ZIP Code

Medical coverage

☐ Cover

☐ Remove from medical

Reason:

Dental coverage

☐ Cover

☐ Remove from dental

Reason:

Tobacco use premium surcharge

Does the tobacco use premium surcharge apply to your dependent? (Response required for dependents ages 13 and older.) Check one.

☐ **Yes, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the date their tobacco use changed.
Date of change (mm/dd/yyyy)

☐ **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 *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Subscriber's Social Security number

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Last name

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First name

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Social Security number

Sex ☐ M ☐ F

Street address

Address line 2

City

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☐ Cover

☐ Remove from medical

Reason:

Dental coverage

☐ Cover

☐ Remove from dental

Reason:

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Reason:

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Address line 2

City

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Medical coverage

☐ Cover

☐ Remove from medical

Reason:

Dental coverage

☐ Cover

☐ Remove from dental

Reason:

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