Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2019 Employee Enrollment/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **List eligible dependents you wish to cover or remove from coverage. This form replaces all *Employee Enrollment/Change* forms previously submitted.**

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

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 1.)*

Changes you can make anytime

❑ Name change ❑ Address change *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 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: ____________________

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)
❑ Remove dependent(s)
❑ Change medical plan
❑ Change dental plan
❑ Enroll after waiving medical coverage
❑ Waive medical 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 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.** However, if adding a newborn or newly adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.

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.

❑ **Add dependent(s)**
❑ **Enroll after waiving medical coverage**
❑ **Change medical plan**
❑ **Change dental plan**
❑ **Remove dependent(s)**
❑ **Waive medical coverage due to enrollment in other employer-based group medical, a TRICARE plan, Medicare, Medicaid, or a state Children's Health Insurance Plan (CHIP)**

(this section continued on next page)

This section to be completed by employer.			
Agency name	Agency/subagency	Eligibility date	Insurance effective date

2019 Employee Enrollment/Change

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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.

- ❑ Marriage, registering a state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. Also complete a *Declaration of Tax Status* form if adding a non-qualified tax dependent.
- ❑ 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).

The following 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 an *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 another 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.

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 has a change in residence that affects health plan availability.
- ❑ 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 that could function as a reduction in benefits for the employee or their dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

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.

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

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 from above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Work phone number ( )	Home phone number ( )

Are you or any eligible dependents already enrolled in PEBB insurance coverage under another account? ❑ **Yes** ❑ **No**
If yes, please contact your personnel, payroll, or benefits office for assistance.

Medical coverage ❑ Cover ❑ Waive: effective date ___________________________
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.)

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you or a dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check YES or leave this section blank, you will be charged the monthly $25 premium surcharge. See the *2019 Premium Surcharge Help Sheet* available at **www.hca.wa.gov/erb** 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 start date your tobacco use changed ___________________

❑ **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 the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

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 by Washington Administrative Code 182-12-260(2), 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 the spouse or state-registered domestic partner will not be enrolled.
- A list of documents we will accept to verify the dependent's eligibility is available at **www.hca.wa.gov/erb.**

Relationship to subscriber
(If adding a state-registered domestic partner, please attach a completed *Declaration of Tax Status* form.)

❑ Spouse: date of marriage ___________________

❑ State-registered domestic partner: date registered _____________________

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

Date of birth (mm/dd/yyyy)	

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.** My spouse or state-registered domestic partner has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed ___________________

❑ **NO, I am not subject to the $25 premium surcharge.** My spouse or state-registered domestic partner has not used tobacco products in the past two months, or they have enrolled in or accessed the tobacco cessation resources noted in the *2019 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 monthly premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and your spouse or state-registered domestic partner has elected not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan Classic. See the *2019 Premium Surcharge 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, or you will be charged the premium surcharge.

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 *2019 Premium Surcharge Help Sheet* and completed the *2019 Spousal Plan Calculator* online.

❑ **NO, I am not subject to the $50 premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and, if needed, completed the *2019 Spousal Plan Calculator* online.

→ ***If NO,* which questions, if any, on the *2019 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

❑ **Employer to determine if premium surcharge applies.** I used the *2019 Premium Surcharge Help Sheet* and am completing and submitting a printed *2019 Spousal Plan Calculator*. My employer will determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to UMP Classic and if I am subject to the premium surcharge.

The *2019 Premium Surcharge Help Sheet* and the *2019 Spousal Calculator* are available at **www.hca.wa.gov/erb**.
To change your previous attestation, use the *2019 Premium Surcharge Change Form.*

(continued)

2019 Employee Enrollment/Change

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

Section 3: Dependent Information (list eligible dependents including children as defined in WAC 182-12-260(3)).

Use additional forms for more members.

- List eligible dependents 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 dependent, you must provide proof of eligibility for each dependent within the PEBB Program's enrollment timelines or the dependent will not be enrolled. If adding a non-qualified tax dependent, also attach a *Declaration of Tax Status form*.
- If enrolling an extended dependent also attach an *Extended Dependent Certification* form.
- If enrolling a dependent with a disability age 26 or older, also submit a completed *Certification of Dependent With a Disability* form and return as instructed on the form. Refer to the *2019 Employee Enrollment Guide* for eligibility information.
- A list of documents we will accept to verify dependent eligibility is available at **www.hca.wa.gov/erb.**

1

Last name	First name	Middle initial	Social Security number

Relationship to subscriber
- ❑ Child
- ❑ Stepchild *(not legally adopted)*
- ❑ Extended dependent *(attach copy of court order)*
- ❑ Disabled *(check only if age 26 or older)*

Sex ❑ M ❑ F

Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber)	Apt./unit number	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 this 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 start date their tobacco use changed ____________

❑ **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 the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

2

Last name	First name	Middle initial	Social Security number

Relationship to subscriber
- ❑ Child
- ❑ Stepchild *(not legally adopted)*
- ❑ Extended dependent *(attach copy of court order)*
- ❑ Disabled *(check only if age 26 or older)*

Sex ❑ M ❑ F

Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber)	Apt./unit number	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 this 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 start date their tobacco use changed ____________

❑ **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 the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

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

Section 3: Dependent Information (such as a child) ***Use additional forms for more members.***

3

Last name	First name	Middle initial	Social Security number

Relationship to subscriber
❑ Child
❑ Stepchild *(not legally adopted)*
❑ Extended dependent *(attach copy of court order)*
❑ Disabled *(check only if age 26 or older)*

Sex ❑M ❑F

Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	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 this 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 start date their tobacco use changed ______

❑ **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 the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

4

Last name	First name	Middle initial	Social Security number

Relationship to subscriber
❑ Child
❑ Stepchild *(not legally adopted)*
❑ Extended dependent *(attach copy of court order)*
❑ Disabled *(check only if age 26 or older)*

Sex ❑M ❑F

Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	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 this 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 start date their tobacco use changed ______

❑ **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 the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

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

Section 4: Medical Plan Selection *Check only one.*

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

Kaiser Foundation Health Plan of the Northwest[1]

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

Kaiser Foundation Health Plan of Washington[1]

- ❑ 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[1,4]
- ❑ UMP Plus–UW Medicine Accountable Care Network[1]

[1] These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must report your new address to your personnel, payroll, or benefits office **no later than 60 days** after you move. If your chosen plan has a change in contracted service area, you may need to change your plan. You must select a new plan within 60 days of the plan becoming unavailable in your area.

[2] Kaiser Foundation Health Plan of the Northwest, with plans offered 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.

[4] This plan **does not** have network primary care providers for adults in Thurston County.

Section 5: 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 will select and receive care from a primary care dental provider in the Willamette Dental Group Plan.
Call Willamette at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

Please sign and date the next page.

(continued)

2019 Employee Enrollment/Change

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

Section 6: 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 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 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, 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, 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 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.

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 **www.hca.wa.gov/erb.**

Subscriber's signature ______________________ **Date** ______________

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

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

2019 PEBB Program Medical Contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101-1374
In 2018: 1-888-901-4636 • **In 2019:** 1-866-648-1928
or TTY: 1-800-833-6388

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

2019 PEBB Program Dental Contractors

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

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

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)

2019 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

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