PUBLIC EMPLOYEES BENEFITS BOARD

2019 Retiree Coverage Election Form

Check one:

- ☒ **Enrolling:** I am a new retiree or a surviving dependent **applying** for coverage.
- ☐ **Deferring:** I am a new retiree or a surviving dependent **deferring** (postponing) my coverage. See pages 29-32 in *2019 Retiree Enrollment Guide* for details about deferring.
- ☐ **Enrolling after deferring:** Date other qualifying medical coverage ended __________.
- ☐ **Separating:** Eligible under Plan 3 retirement plan, **separating** as of __________.

Required **Retiree or employee information only**	Retiree or employee name Harry Husky		
	Social Security number 123-45-6789	Retirement plan	Retirement date 7/1/2019

For new Washington State school district, charter school, or educational service district (ESD) retirees only	School district n/a
	When does your current medical/dental coverage through your school district, charter school, ESD, or COBRA end? ______________ (mm/dd/yyyy). **Note:** If you are applying to enroll in retiree insurance coverage after your COBRA coverage ends, you must submit proof of your continuous health coverage with this form.

Section 1: Subscriber information *See attached instruction sheet for more information.*

Social Security number	Last name	First name	Middle initial	Sex
123-45-6789	Husky	Harry		☒ M ☐ F

Street address	Apt./unit number	City	State	ZIP Code
123 Main Street		Seattle	WA	98119
Mailing address (if different than above)	**Apt./unit number**	**City**	**State**	**ZIP Code**

County of residence	Date of birth (mm/dd/yyyy)	Home phone number	Alternate phone number
King	5/1/1950	(206) 123-4567	( )

Subscriber enrollment

A. Enroll: ☐ Medical only ☒ Medical and dental ☐ Retiree term life insurance

B. 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 begin and end dates).
  Date other coverage ended __________________

If deferring or enrolling after deferring, check the box below that applies to you.

- ☐ Enrolled in a PEBB Program, Washington State school district, charter school, or educational service district-sponsored health plan as a dependent.
- ☐ Enrolled in employer-based group medical as an employee or employee's dependent, including COBRA coverage or continuation coverage. This does not include an employer's retiree coverage.
- ☐ Enrolled in medical coverage as a retiree or dependent in a TRICARE plan, CHAMPVA, 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 (Washington Apple Health) 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.
- ☐ **Non-Medicare retirees only:** Enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

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

(continued)

EXAMPLE

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 2: Spouse or state-registered domestic partner information

See attached instruction sheet for more information.

Social Security number	Last name	First name	Middle initial	Sex	Date of birth (mm/dd/yyyy)
987-65-4321	Husky	Mary		☐ M ☒ F	3/1/1950

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

A. Relationship to subscriber ☒ Spouse: date of marriage 8/1/1985

☐ State-registered domestic partner: date registered ___________

B. Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. For instructions, see the *2019 Premium Surcharge Help Sheet* at www.hca.wa.gov/pebb-retirees. **If you check YES below or leave this section blank, you will be charged the monthly $50 monthly premium surcharge in addition to your monthly premium.**

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

☒ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ **YES, I am a non-Medicare subscriber and am subject to the $50 monthly premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and completed the 2019 Spousal Plan Calculator.

☐ **NO, I am a non-Medicare subscriber and am not subject to the $50 monthly premium surcharge.** I used the *2019 Premium Surcharge Help Sheet* and if needed, completed the 2019 Spousal Plan Calculator online.

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

☐ I am completing and submitting the 2019 Spousal Plan Calculator found at **www.hca.wa.gov/erb** for the PEBB Program to determine.

Section 3: Dependent information

See attached instruction sheet for more information.

1

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

Relationship to subscriber	Date of birth (mm/dd/yyyy)		
		☐ Child ☐ Stepchild (not legally adopted) ☐ Extended dependent (attach copy of court order)	☐ Disabled (check only if age 26 or older)

Street address Apt./unit number	City	State	ZIP Code

2

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

Relationship to subscriber	Date of birth (mm/dd/yyyy)		
		☐ Child ☐ Stepchild (not legally adopted) ☐ Extended dependent (attach copy of court order)	☐ Disabled (check only if age 26 or older)

Street address Apt./unit number	City	State	ZIP Code

(continued)

EXAMPLE

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 4: Medicare enrollment *See attached instruction sheet for more information.*

Subscriber	Spouse/state-registered domestic partner	Dependent 1	Dependent 2
A. Enrolled in Medicare Part(s) A (hospital) and/or B (medical)?*			
Part A ☒ Yes ☐ No Effective date 5/1/2015 Part B ☒ Yes ☐ No Effective date 7/1/2019	Part A ☒ Yes ☐ No Effective date 3/1/2015 Part B ☒ Yes ☐ No Effective date 7/1/2019	Name: ______ Part A ☐ Yes ☐ No Effective date ______ Part B ☐ Yes ☐ No Effective date ______	Name: ______ Part A ☐ Yes ☐ No Effective date ______ Part B ☐ Yes ☐ No Effective date ______
B. Enrolled in Medicare Part D (prescription drug coverage)? If yes, you may only enroll in Medicare Supplement Plan F, administered by Premera Blue Cross.			
Part D ☐ Yes ☒ No Effective date ______	Part D ☐ Yes ☒ No Effective date ______	Part D ☐ Yes ☐ No Effective date ______	Part D ☐ Yes ☐ No Effective date ______
C. Enrolled in Medicaid with Medicare Part D?			
☐ Yes ☒ No Effective date ______	☐ Yes ☒ No Effective date ______	☐ Yes ☐ No Effective date ______	☐ Yes ☐ No Effective date ______
D. Receiving Social Security Disability?			
☐ Yes ☒ No Effective date ______	☐ Yes ☒ No Effective date ______	☐ Yes ☐ No Effective date ______	☐ Yes ☐ No Effective date ______

*If yes, proof is required. Attach a copy of your or your dependent's Medicare card (or all pages of the entitlement letter) to this form if we don't already have a copy. Write your full name and last four digits of your Social Security number on the copy.

Section 5: Tobacco use premium surcharge *See attached instruction sheet for more information.*

Only complete this section if you are not enrolled in Medicare Part A and Part B. The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B and you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. **If you check YES or leave this section blank** for you and any enrolled dependents, you will be charged the premium surcharge. See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

Subscriber	Spouse/state-registered domestic partner	Dependent 1	Dependent 2
☐ **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 the tobacco cessation resources noted in the *Premium Surcharge Help Sheet.*	☐ **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. ☐ **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 has enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet.*	Name______ ☐ **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 has enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet.*	Name______ ☐ **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 has enrolled in or accessed the tobacco cessation resources noted in the *Premium Surcharge Help Sheet.*

(continued)

EXAMPLE

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 6: Medical plan selection *See attached instruction sheet for more information.*

Kaiser Foundation Health Plan of the Northwest[7]

- ☐ Kaiser Permanente NW Classic[8]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[4,8]
- ☐ Kaiser Permanente NW Senior Advantage[1]

Kaiser Foundation Health Plan of Washington[7]

- ☐ Kaiser Permanente WA Classic
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[4]
- ☒ Kaiser Permanente WA Medicare Plan[1,2]
- ☐ Kaiser Permanente WA SoundChoice[3, 10]
- ☐ Kaiser Permanente WA Value[3]

☐ **Premera Blue Cross Medicare Supplement Plan F**[5]

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan[4]
- ☐ **UMP Plus** (select a network)
- ☐ UMP Plus–Puget Sound High Value Network[6,7,9]
- ☐ UMP Plus–UW Medicine Accountable Care Network[6,7]

1. These Medicare Advantage plans are available in certain counties to Medicare enrollees. Also complete and attach Form C if you live in a county where Medicare Advantage is available.
2. If you cover dependents not enrolled in Medicare Part A and Part B, you may also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.
3. This plan is available only if at least one member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA's Medicare Plan.
4. These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate your dependent's PEBB coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.
5. Also complete and return Form B to enroll in Premera Blue Cross Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.
6. This plan is not available to Medicare Part A and Part B retirees and their dependents.
7. These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program **no later than 60 days** after you move.
8. Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.
9. This plan does not have network primary care providers for adults in Thurston County.
10. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

Section 7: Dental plan selection *See attached instruction sheet for more information.*

You must enroll in medical coverage to enroll in dental. **If you enroll in dental, you must remain enrolled for at least two years.** Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans, not your dentist, for benefits information. The plans' contact information is located at the end of this form.

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) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan.

(continued)

EXAMPLE

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 8: Retiree Term Life Insurance election *See attached instruction sheet for more information.*

Retiree term life insurance is available only if you receive PEBB life insurance as an 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 plans.
To apply for retiree term life insurance, complete and return 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.

Section 9: Payment authorization *See attached instruction sheet for more information.*

Your first premium payment and applicable premium surcharge are due to the Health Care Authority **no later than 45 days** after your 60-day election period ends. You must make the first payment before you will be enrolled.

How would you like to pay your medical, dental, and life insurance premiums (if elected) and any applicable premium surcharges?	How to make the first payment
☐ **Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and any applicable premium surcharges I am required to pay from my retirement pension. Deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.	If you select pension deduction, the PEBB Program will send you an invoice if a first payment is needed. After that, you will receive an invoice each month and must pay by check until your pension deduction is set up. PEBB must receive the payment by the date shown on the invoice.
☐ **Invoicing:** I will pay my medical and dental (if elected) premiums and any applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. ☐ **Electronic Debit Service (EDS):** I will complete and submit the *Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. I will pay my monthly premium(s) and any applicable premium surcharges by check until notified of my EDS effective date. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. To pay by EDS for your retiree term life insurance, contact MetLife at 1-866-548-7139.	If you select one of the options at the left for your medical and dental premium with any applicable surcharges, make your check payable to **Health Care Authority.** Send it (with your EDS form, if elected) to: Washington State Health Care Authority PO Box 42691 Olympia, WA 98504-2691 Your first payment is due no later than 45 days after your 60-day election period ends.

Note: You cannot have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage, or continuation coverage ended. Premiums and any 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.

(continued)

2019 Retiree Coverage Election Form

Subscriber's last name	First name	Middle initial	Social Security number
Husky	Harry		123-45-6789

Section 10: Signature

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 may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime and can result in imprisonment, fines, and denial of PEBB 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 any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly premium (if I am not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, I must remain enrolled in retiree dental for at least two years unless I defer coverage as described in Section 1, or enroll in employer-based group dental insurance or such coverage under COBRA or continuation coverage as an employee or dependent of an employee.

I also understand that it is my responsibility to verify my dentist is covered by the dental plan network I selected.

I understand if I or any enrolled dependent are entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.

If I choose to defer medical/dental, I understand I can enroll or reenroll no later than 60 days after losing other qualifying medical coverage or during the PEBB Program's annual open enrollment period (November 1-30) as long as there has been no gap in qualifying coverage and I provide proof of continuous enrollment. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or the last day of the PEBB Program's annual open enrollment period. If I defer enrollment for myself, I cannot enroll my eligible dependents except as allowed under PEBB rules. I understand in most cases, enrollment will be deferred effective the first of the month following the date this form is received by the PEBB Program unless a future date is provided.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand the PEBB Program will direct a portion of my monthly premium to an HSA based on the information I have provided, and that there are limits to these contributions and my HSA contributions, if any, under federal tax law.

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

This form replaces all *Retiree Election or Change Forms* previously submitted to the PEBB Program. If I am a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with 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 rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

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.

Be sure to sign and date this form and keep a copy for your records.
Mail completed form and documentation to:
Washington State Health Care Authority, PEBB Program, PO Box 42684, Olympia, WA 98504-2684 **or fax to:** 360-725-0771
Questions? Visit our website at **www.hca.wa.gov/pebb-retirees** or call us at 1-800-200-1004.

Subscriber's signature Harry Husky Date 6/15/2019

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

2019 PEBB Medical Contractors

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

Premera Blue Cross
P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

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

2019 PEBB Dental Contractors

DeltaCare,
administered by Delta Dental of Washington
400 Fairview NE, Suite 800, Seattle, WA 98109-5371

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

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

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

Retiree Coverage Election Form (Form A) instructions

All forms and documents mentioned here are available at **www.hca.wa.gov/pebb-retirees** under *Forms & publications.*

Note: If you are already enrolled in Public Employees Benefits Board (PEBB) coverage and need to make changes to your existing retiree account, **complete the *Retiree Coverage Change Form* (Form E).**

Before you begin

Use these instructions to complete Form A. The form must be typed or printed clearly in dark ink. Do not return these instructions with Form A.

Timelines to enroll

If you are...	The PEBB Program must receive Form A...
A new retiree (or separating employee eligible under Plan 3 retirement) applying to enroll	**No later than 60 days** after your employer-paid coverage*, COBRA coverage, or continuation coverage ends*
A new retiree **deferring (postponing) enrollment** in a PEBB retiree health plan	**In most cases, no later than 60 days** after your employer-paid coverage*, COBRA, or continuation coverage ends*. You must maintain continuous enrollment in other qualifying coverage while you defer your enrollment. For more information and timelines about deferring, see the *Retiree Enrollment Guide* or visit **www.hca.wa.gov/pebb-retirees** and click on *Defer retiree coverage.*
An eligible elected or full-time appointed official of the legislative or executive branch of state government	**No later than 60 days** after you leave public office
A dependent becoming eligible as a survivor (not including emergency service personnel killed in the line of duty)	• For an eligible survivor of an employee who passes away, no later than 60 days after the later of the date of the employee's death or the date your PEBB, school district, educational service district, or charter school coverage ends. • For an eligible survivor of a retiree who passes away, no later than 60 days after the date of the retiree's death.
Enrolling after deferring coverage	No later than 60 days after the date your other qualifying coverage ends. Proof of continuous coverage in one or more qualifying coverages from the date of deferral will be required (with begin and end dates).

Additional forms or documents you may need to complete and submit with Form A

- If enrolling in Premera Blue Cross Medicare Supplement Plan F, you must also complete and submit the Group Medicare Supplement Enrollment Application **(Form B).**
- If enrolling in a Medicare Advantage plan, you must also complete and submit the *Medicare Advantage Plan Election Form* **(Form C).**
- If enrolling a state-registered domestic partner or the partner's child, you must also complete and submit the *Declaration of Tax Status form*.
- If enrolling a dependent with a disability age 26 or older, you must also complete and submit the *Certification of Dependent with a Disability* form and return as instructed on the form.
- If enrolling an extended dependent, you must also complete and submit the *Extended Dependent Certification* form.
- If enrolling in life insurance, also complete and submit the *MetLife Enrollment/Change form for retiree Plan* form

Submit dependent verification documents if:

- You are enrolling a state-registered domestic partner and/or their dependents.
- You (the subscriber) are not enrolled in Medicare Part A and Part B and are enrolling a dependent.

A list of documents we will accept to verify your dependent's eligibility is available in the *Retiree Enrollment Guide* or at **www.hca.wa.gov/pebb-retirees.**

How to submit your completed enrollment form(s) and documentation

Mail to	Washington State Health Care Authority PEBB Program PO Box 42684 Olympia, WA 98504-2684	**Electronically submit:** Send a secure online message to PEBB Customer Service by registering for an account at **www.fuzeqna.com/pebb/consumer/question.asp.** **Note:** You must sign and date any forms you attach to a secure online message.
Fax to:	360-725-0771	

How to submit your first payment (required even if you chose electronic debit service)

Your first premium payment and any applicable premium surcharge(s) are due **no later than 45 days** after your 60-day election period ends. You must make the first payment before you will be enrolled.

Please make checks payable to Health Care Authority and send to:

Health Care Authority
PO Box 42691
Olympia, WA 98504-2684

(continued)

How to complete Form A

After you complete each section of the form that applies to you, check it off. Do not return the checklist below with your Form A.

☐ Required information section

- Print the name of the retiree, Social Security number (SSN), retirement plan (e.g. PERS, TRS, SERS, etc.), retirement date, and other appropriate information.
- If you are a surviving spouse, surviving state-registered domestic partner (defined in WAC 182-12-260(2)), or surviving dependent, provide the SSN of the deceased retiree or employee in the "Retiree or employee information only" section. Provide your SSN and information in Section 1: Subscriber Information.

☐ Section 1: Subscriber information

- Print your information in the subscriber section.
- Check your enrollment election choice. You can enroll or defer.
  - A. **Enroll.** If you are enrolling, check the appropriate box(es).
  - B. **Defer.** If you are deferring (postponing) coverage or enrolling after deferring, check the appropriate box and identify the deferral reason. The reasons listed are the **only** reasons you can defer enrollment in a PEBB retiree health plan. See page 1 for deferral information.

☐ Section 2: Spouse or state-registered domestic partner information

Only complete this section if you want to cover an eligible spouse or state-registered domestic partner (as defined in WAC 182-12-260(2)).

Subscribers **not** enrolled in Medicare Part A and Part B must also:

A. Provide proof of your spouse/state-registered domestic partner's dependent eligibility within PEBB's enrollment timelines, **and**

B. Attest to the spouse or state-registered domestic partner coverage premium surcharge. The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. For help determining whether you need to attest, see the *2019 Premium Surcharge Help Sheet* in the *2019 Retiree Enrollment Guide*. You can also visit **www.hca.wa.gov/pebb-retirees** and click on *Surcharges* for more information.

Note: If adding a state-registered domestic partner, attach a completed *Declaration of Tax Status* form and proof of dependent eligibility within PEBB's enrollment timelines.

☐ Section 3: Dependent information

Only complete this section if you want to cover eligible dependents, including children as defined in WAC 182-12-260(3). Dependents cannot be enrolled on two PEBB medical or dental accounts at a time.

Non-Medicare subscribers: If you are enrolling dependents, you must also provide proof of dependent eligibility for each dependent within PEBB's enrollment timelines or they will not be enrolled.

- If enrolling a **state-registered domestic partner's child**, also complete and submit the *Declaration of Tax Status* form and proof of the dependents eligibility.
- If enrolling a **dependent with a disability** age 26 or older, also complete and submit the *Certification of Dependent with a Disability* form and return as instructed on the form.
- If enrolling an **extended dependent**, also complete and submit the *Extended Dependent Certification* form.

☐ Section 4: Medicare enrollment information

Check the appropriate boxes to indicate the Medicare enrollment status for you and any enrolled dependents. Respond to the following questions:

A. **Enrolled in Medicare Part(s) A and/or B?** If yes, proof is required. If we don't already have a copy of your or your dependent's Medicare card, attach a copy of the enrollee's card or a copy of all pages of the entitlement letter to Form A. Write your full name and last four digits of your Social Security number on the copy.

B. **Enrolled in Medicare Part D (prescription drug coverage)?** If yes, you may only enroll in Premera Blue Cross Medicare Supplement Plan F.

C. **Enrolled in Medicaid with Medicare Part D?**

D. **Receiving Social Security Disability?**

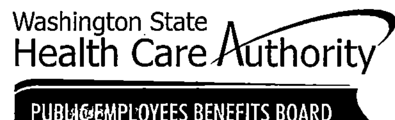
☐ Section 5: Tobacco use premium surcharge

Only complete this section if you are not enrolled in Medicare Part A and Part B (Non-Medicare) You only need to complete this section if you are changing an existing attestation or are enrolling new dependents. Responses are only required for dependents age 13 or older.

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you are **not** enrolled in Medicare Part A and Part B and you or an eligible dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. **If you check YES or leave this section blank** for you and any enrolled dependents, you will be charged the premium surcharge. See the *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb-retirees** for instructions on how to respond.

☐ Section 6: Medical plan selection
Check the box for the medical plan you wish to enroll in Check the box for the medical plan you are eligible for and wish to enroll in. You may need to complete and submit additional forms, which are listed in the right column of Section 6.
☐ **Section 7: Dental plan selection**
Only complete this section if you are enrolling in dental coverage. You must enroll in medical coverage to enroll in dental. • If you select dental coverage for yourself, **you must keep dental coverage for yourself and any enrolled dependents for at least two years** unless you defer or terminate enrollment as described in PEBB Program rules (WA 182-12-208). • Before you select a dental plan, call the plan (not your dentist) to make sure your provider participates with the plan.
☐ **Section 8: Retiree Term Life election**
Only complete this section if you are eligible for and electing to enroll in Retiree Term Life Insurance. You must also submit the MetLife enrollment/change form for Retiree Plan with Form A. If you do not submit the MetLife form, you may miss your opportunity to enroll. If we determine that you are not eligible for retiree term life insurance, you will receive a denial letter with your appeal rights.
☐ **Section 9: Payment authorization**
Choose the method for your first payment (and any applicable premium surcharges). Read this section carefully, as your first payment may be required to begin coverage. Your first premium payment and applicable premium surcharge are due to the Health Care Authority no later than 45 days after your 60-day election period ends. If you choose Electronic Debit Service (EDS), also complete and submit the Electronic Debit Service Agreement form. You must make the first payment before you will be enrolled. Mail your payment and the EDS form, if elected, to the address listed in this section.
☐ **Section 10: Signature**
Read Section 10 carefully to understand your responsibilities for Form A. Then sign and date this section to complete your enrollment form. **Mail Form A and any other required forms** to the address listed in this section.

EXAMPLE



C

2019 Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read and sign page 2 of this form.

Section 1: Retiree information				Medical effective date (mm/dd/yyyy) 07/01/2019		
Social Security number 123-45-6789	Last name (as it appears on Medicare card) Husky	First name Harry	Middle initial	Sex ☒ M ☐ F		
Permanent residential address (required) 123 Main Street	Apt./unit number	City Seattle	State WA	ZIP Code 98119		
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code		
County of residence King	Date of birth (mm/dd/yyyy) 05/01/1950	☒ Married (mm/dd/yyyy) 08/01/1985	☐ State-registered domestic partnership/legal union (mm/dd/yyyy)	Home phone number (with area code) 206-123-4567		
Retiree Medicare claim number from Medicare card	**Entitled to Part A (hospital)** ☒ Yes ☐ No If yes, effective date 05/01/2015					
	Entitled to Part B (medical) ☒ Yes ☐ No If yes, effective date 07/01/2019					

Section 2: Spouse or state-registered domestic partner information *(if applying)*				
Social Security number 987-65-4321	Last name (as it appears on Medicare card) Husky	First name Mary	Middle initial	
Permanent residential or mailing address 123 Main Street		Date of birth 03/01/1950	Sex ☐ M ☒ F	
City Seattle		State WA	ZIP Code + 4 98119	
Spouse or state-registered domestic partner's Medicare claim number from Medicare card	**Entitled to Part A (hospital)** ☒ Yes ☐ No If yes, effective date 03/01/1950			
	Entitled to Part B (medical) ☒ Yes ☐ No If yes, effective date 07/01/2019			

Section 3: Plan choice

Kaiser Foundation Health Plan of the Northwest

☐ Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington

☒ Kaiser Permanente WA Medicare Advantage

Name of **retiree's** contracting primary care provider (refer to plan's provider directory) Dr. John Wu	Current patient? ☒ Yes ☐ No
Name of **spouse's or state-registered domestic partner's** contracting primary care provider (refer to plan's provider directory) Dr. John Wu	Current patient? ☒ Yes ☐ No

Please return this form by mail to:

Washington State Health Care Authority
PO Box 42684
Olympia, WA 98504-2684 **or fax to:** 360-725-0771

(continued)

EXAMPLE

Section 4: Medical information	Retiree	Spouse or state-registered domestic partner
1. Do you currently have end-stage renal disease (kidney disease)?	☐ Yes ☒ No	☐ Yes ☒ No
2. Do you have any health insurance other than Medicare?	☒ Yes ☐ No	☒ Yes ☐ No
If yes, through which carrier? PEBB Employer Coverage	What type of policy? Group Medical	
Do you intend to discontinue this policy?	☐ Yes ☒ No	☐ Yes ☒ No
Note: Your answers to questions 3 and 4 below will **not** affect your eligibility to enroll in a Medicare Advantage plan.		
3. Do you live in an institution?	☐ Yes ☒ No	☐ Yes ☒ No
If yes, name of institution:	Date of admission:	
Address:	Phone number:	
4. Are you currently receiving Medicaid?	☐ Yes ☒ No	☐ Yes ☒ No
If yes, Medicaid number:		

Signature and authorization

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 law, 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 qualified. 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. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

I have read and understand this form, including the Statement of Understanding (on the next page). I know that I must refer to my plan's certificate of coverage for rules I must follow to receive coverage under this Medicare Advantage contract.

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 rules and policies may result in my benefits selection being rejected or defaulted.

This form cannot be signed more than 90 days before the effective date of this coverage. (*See Statement of Understanding on the next page for Medicare Advantage Plan coverage effective date.)

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.**

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS.

Signature of retiree	Date	Signature of spouse or state-registered domestic partner (if enrolling)	Date
Harry Husky	06/15/2019	Mary Husky	06/15/2019

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where they reside) on this application means that I have read and understand the contents of the application. If signed by an authorized representative (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from the Medicare Advantage plan or by Medicare.

If you are the authorized representative, you must sign below and provide the following information:

Signature of authorized representative	Date

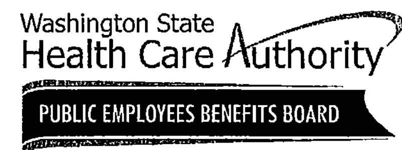
Name	Relationship to retiree
Address	Phone

HCA is committed to providing equal access to our services.
If you need accommodation, please call 1-800-200-1004 (TRS: 711).

EXAMPLE

**Electronic debit service is only available to PEBB retiree and continuation coverage subscribers.
If you are making your first payment, pay by check or money order.**

Electronic Debit Service Agreement



Electronic debit service (EDS) allows PEBB subscribers to have monthly payments automatically taken from a checking or savings account. To enroll in EDS, please complete this form. Type or print clearly in black ink.

I am submitting this form to (check one):

☒ Start an electronic debit service from my bank account.

☐ Change my electronic debit service bank account.

Subscriber's Information	
Subscriber's name (please print) Harry Husky	PEBB account number or subscriber's Social Security number 123-45-6789

Bank Account Information			
Account holder's name (if different from above; please print)			
Name of financial institution Bank of America		Branch address 4701 University Way	
City Seattle	State WA	ZIP Code 98119	Bank routing number 123456789
☒ Checking ☐ Savings (Check one)	Account number 456789		

I hereby authorize the Health Care Authority (HCA) to start electronic funds transfers from the financial institution named above. I understand my authorization remains in effect until I give written notice to HCA, which I must do at least 15 business days before my next monthly withdrawal. If I want to change the checking or savings account that HCA withdraws from, I will submit a new Electronic Debit Service Agreement form at least 15 business days before the next withdrawal.

Withdrawals will occur on the 15th day of each month that I have PEBB insurance coverage, and will be in the amount of my monthly invoice. If the 15th falls on a Saturday, Sunday, or holiday, the withdrawal will occur on the next business day. HCA will notify me of payments returned for insufficient funds or closed accounts, and provide payment instructions.

HCA reserves the right to change or terminate this agreement as an account payment method for any reason and at any time by giving proper notice of at least 15 business days.

Signature **(Must be signed by the bank account holder to authorize debit service)**	Date 6-15-2019

To complete your authorization process:

☐ Make sure you have filled out the entire form, including your signature above.

☐ Enclose a **voided check** or a **deposit slip**, and send to:

Health Care Authority
Attn: Accounting
P.O. Box 42691
Olympia, WA 98504-2691

Remember!

You must continue to pay your premiums and any applicable premium surcharges as invoiced until you receive a letter from HCA with your EDS start date. EDS approval takes six to eight weeks.

You must submit a new *Electronic Debit Service Agreement* form to HCA when your bank account information changes.

Questions? Call the PEBB Program at 1-800-200-1004 and choose option 4 to speak to accounting.

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the first page of this form, 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 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 that (s)he may begin using the plan services as of the effective date of enrollment.

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

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

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

2019 PEBB MEDICAL CONTRACTORS

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-877-221-8221 or TRS: 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