2025 PEBB Retiree Election Form (form A)

HCA | Health Care Authority
Public Employees Benefits Board

Clear form

Instructions – Read before completing form

Submit this form to enroll in or defer (postpone) PEBB retiree insurance coverage. If you wish to make a change to an existing retiree account, use Benefits 24/7 at **benefits247.hca.wa.gov** or the *PEBB Retiree Change Form* (form E). To review eligibility guidelines for retiree coverage (per WAC 182-12-171), see the Retiree eligibility section of the *Retiree Enrollment Guide*. All forms and documents mentioned are available on HCA's website at **hca.wa.gov/pebb-retirees**.

We use the term "non-Medicare" throughout this form. This means you are not enrolled in Medicare Part A and Part B.

Type or print in dark ink using all capital lettering: J O H N

⚠ Remember to read Section 9 and sign Section 10. This form replaces all retiree election or change forms submitted in the past.

Required General information

Subscriber information only.

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

Subscriber last name: HUSKY

Social Security number: 123-45-6789

Washington state-sponsored retirement plan: HERP OR DRS PLAN EX PERS 2

Retirement date (or separation date for Plan 2, Plan 3, or higher-education retirement plans): 07-01-2025

Check one:

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

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

☐ **Enrolling after deferring:** Date other qualifying medical coverage ended

☐ **Separating**: Eligible under Plan 2, Plan 3, or a higher-education retirement plan, separating as of (mm/dd/yyyy)

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

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

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

- ☐ Enrolled as a dependent in a health plan sponsored by the PEBB Program, or the School Employees Benefits Board (SEBB) Program. (This includes under COBRA or continuation coverage.)
- ☑ Enrolled in employer-based group medical as an employee or employee's dependent, including medical insurance continued under COBRA or continuation coverage. **This does not include an employer's retiree coverage**.
- ☐ Enrolled in medical coverage as a retiree or dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program. (You have a one-time opportunity to enroll in a PEBB retiree health plan.)
- ☐ Enrolled in a Medicaid program that provides creditable coverage in Medicare Part A and Part B. (You may continue to cover eligible dependents who are not eligible for creditable coverage under Medicaid.)
- ☐ Enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). (You have a one-time opportunity to enroll in a PEBB retiree health plan.)
- ☐ **Non-Medicare subscribers only**: Enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). (You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.)
- ☐ **Medicare subscribers only**: Effective January 1, 2025, retirees and survivors enrolled in Medicare may defer enrollment if they permanently live outside of the United States.

Subscriber's last name: HUSKY

Social Security number: 123-45-6789

1 Subscriber

If you are enrolled in Medicare, this information needs to match your Medicare record to avoid delay to coverage starting.

Social Security number: 123-45-6789

Date of birth (mm/dd/yyyy): 05/01/1955

Sex assigned at birth[1]: ✔ Male ☐ Female

Last name: HUSKY

Gender identity[2]: ✔ Male ☐ Female ☐ X

First name: HARRY

Middle initial:

Suffix:

Phone number: 206-543-4444

Alternate phone number:

Street address (PO Box is not allowed): 123 Main Street

Address line 2:

City: SEATTLE

State: WA

ZIP/Postal code: 98119

County: KING

Mailing address (if different):

Mailing address line 2:

City:

State:

ZIP/Postal code:

County:

Are you enrolled in Medicare Part A or Part B?

Part A (hospital) ☐ Yes ☐ No

If Yes, enter effective date on your Medicare card

Part B (medical) ☐ Yes ☐ No

If Yes, enter effective date on your Medicare card

Medicare number

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

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

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. Refer to the *Retiree Enrollment Guide* or visit HCA's website at **hca.wa.gov/pebb-retirees** to learn more about the tobacco use premium surcharge and how it may apply to you. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use.

Does the tobacco use premium surcharge apply to you? If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. Check one:

- ☐ **No**, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ☐ **Yes**, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.
- ☐ **No**, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *Retiree Enrollment Guide*.

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

2 Spouse or state-registered domestic partner (SRDP)

If enrolling a spouse or SRDP, complete this section. If not, then skip to section 3.

List an eligible spouse or SRDP you wish to cover. SRDP is defined in WAC 182-12-109. State-registered domestic partners include partners of legal unions from another jurisdiction, and that is substantially equivalent to a domestic partnership in Washington State. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. Dependents cannot be enrolled in two PEBB medical, dental, or vision accounts at the same time. You must also provide proof of their eligibility to the PEBB Program or they will not be enrolled. A list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-retirees**.

Relationship to subscriber

☐ Spouse: date of marriage

⚠ If enrolling a spouse, attach proof of their eligibility, such as a marriage certificate or the most recent year's federal tax return (black out financial information).

☐ SRDP (non-Washington State): Partnership start date

☐ SRDP (Washington State): Partnership start date

⚠ If enrolling an SRDP, attach a PEBB Declaration of Tax Status to indicate whether they qualify as a dependent for tax purposes.

If they are enrolled in Medicare, this information needs to match their Medicare record to avoid delay to coverage starting.

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber's. PO Box is not allowed)

Address line 2

City

State

ZIP/Postal code

County

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

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

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

Medicare number

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge.

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

- ☐ **No,** the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ☐ **Yes,** I am subject to the $25 premium surcharge. This person has used tobacco in the past two months.
- ☐ **No,** I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources.

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

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

Answer these questions about your spouse or SRDP for 2025:	**Yes**	**No**
1. Are you covering your spouse or SRDP in a PEBB medical plan under your account?	☐	☐
2. Will they be eligible for medical coverage through their employer? (If they will not be employed in 2025, answer No.)	☐	☐
3. Will their employer offer at least one medical plan that serves their county of residence?	☐	☐
4. Have they chosen not to enroll in their employer's medical (including SEBB) coverage?	☐	☐
5. Will the coverage offered by their employer in 2025 not be through the PEBB Program or a TRICARE plan? Answer Yes if their employer does not offer PEBB coverage or a TRICARE plan. Answer No if their employer offers PEBB coverage or a TRICARE plan.	☐	☐
6. Will their share of the medical premium through their employer be less than $126.36 per month?	☐	☐

If you answered **No** to any of the questions, check No below. You will not be charged the surcharge.
If you answered **Yes** to all of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:
   a. Serve their county of residence.
   b. Have a monthly premium of less than $126.36 per month for the employee.
2. Use the SBC information to answer the questions in the *PEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response below.

⚠ If you check Yes below or do not check any of the boxes below, you will be charged the $50 monthly premium surcharge.

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

- ☐ **No**, the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ☐ **Yes**, I am subject to the $50 premium surcharge. I completed the *PEBB Spousal Plan Calculator*.
- ☐ **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator*.
- ☐ I need the PEBB Program to determine if the premium surcharge applies. I am submitting a printed *PEBB Spousal Plan Calculator*.

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

3 Dependents

If enrolling a dependent, complete this section. If not, then skip to section 4.

List dependents you wish to enroll. Children must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and children age 26 or older with a disability. Dependents cannot be enrolled in two PEBB medical, dental, or vision accounts at the same time.

You must provide proof of eligibility for each dependent to the PEBB Program or the dependent will not be enrolled. A list of documents we will accept to prove dependent eligibility are available on HCA's website at **hca.wa.gov/pebb-retirees**.

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

If enrolling a child with a disability age 26 or older, submit a *PEBB Certification of a Child with a Disability* as instructed on the form. If enrolling an extended dependent, also attach a *PEBB Extended Dependent Certification*.

Relationship to subscriber

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

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Street address (if different from subscriber. PO Box is not allowed)

Address line 2

City

State

ZIP/Postal code

County

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

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

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

Medicare number

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

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

Subscriber's last name

H U S K Y

Social Security number

1 2 3 - 4 5 - 6 7 8 9

Tobacco use premium surcharge

Response required if you are enrolling a dependent age 13 or older in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge.

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

- **No,** the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- **Yes,** I am subject to the $25 premium surcharge. This dependent has used tobacco in the past two months.
- **No,** I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources.

If you are enrolling more than one dependent, please copy the dependent section and include it with your submission.

Subscriber's last name

H U S K Y

Social Security number

1 2 3 - 4 5 - 6 7 8 9

4 Medical plan selection

Contact the plans with questions about benefits and providers. Contact information is at the end of this form. Medicare Advantage plans that include Part D prescription drug coverage are also known as MAPD plans.

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

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

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

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

Premera Blue Cross

- ☐ Medicare Supplement Plan G[7]

Uniform Medical Plan (UMP), administered by Regence BlueShield and ArrayRx

- ☐ UMP Classic[5]
- ☐ UMP Classic Medicare with Part D (PDP)[8]
- ☐ UMP Select[5]
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus–Puget Sound High Value Network[1, 5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[1, 5]

UnitedHealthcare Medicare Advantage Prescription Drug

- ☐ UnitedHealthcare PEBB Balance[8] (MAPD)
- ☐ UnitedHealthcare PEBB Complete[8] (MAPD)

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

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

5 Dental plan selection

You must enroll in medical coverage to enroll in dental. If you enroll in dental coverage, your dependents (if any) will also be enrolled in the same dental plan. Before you enroll, call the dental plan to make sure your provider accepts the specific plan and plan group you choose. Their contact information is 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 must select a primary care dentist in the DeltaCare network.

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

Decline dental enrollment

☐ I decline dental enrollment.

6 Vision plan selection

Available to non-Medicare members only. Choose one vision plan.
Before you enroll, make sure the provider you want to use accepts the specific plan you choose. All non-Medicare members (subscribers or dependents) who want vision benefits must elect a vision plan. For Medicare members, vision is included in your medical plan, excluding Premera Plan G.

☐ **Davis Vision by MetLife**, underwritten by Metropolitan Life Insurance Company ("MetLife")

☐ **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company

☐ **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

Decline vision enrollment

☐ I decline vision enrollment

⚠ Plan contact information is at the end of this form.

7 Retiree term life insurance

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

☐ I want to enroll in retiree term life insurance and acknowledge that I have completed the *MetLife Enrollment/Change Form for Retiree Plan* and will return it with this form.

☑ I decline retiree term life insurance.

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

8 Payment

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

How to make first payment

If you select electronic debit service (EDS) or invoicing below, you must make your first payment by check. **Your first premium payment and applicable premium surcharges are due no later than 45 days after your 60-day election period ends.** If you miss this deadline, you may lose your right to enroll in PEBB retiree insurance coverage.

Make your check payable to Health Care Authority. Send it (and your EDS form, if you choose that option) to:

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

If you select pension deduction below, the PEBB Program will send you an invoice if the first payment is needed. Due to timing issues with the Department of Retirement Systems, your first payment may not be deducted from your pension. If you receive an invoice, you must pay by check.

You cannot have a gap in coverage. Premiums are due back to the first of the month in which your PEBB retiree insurance coverage became effective. Premiums and applicable premium surcharges are for a full month of coverage and cannot be prorated for a partial month. Payments are processed immediately as required by state law.

How would you like to pay?

☐ **Electronic debit service (EDS)**: I will pay my monthly medical, dental (if elected), and vision (if elected) premiums and applicable premium surcharges by EDS. I will submit the *PEBB Electronic Debit Service (EDS) Agreement*. I understand I must pay by check until I am notified of my EDS effective date, and that I must make my first payment before I will be enrolled. I understand I will receive a separate bill from MetLife for my retiree term life insurance (if elected). To pay by EDS for your retiree term life insurance, call MetLife at 1-866-548-7139.

☐ **Pension deduction**: I authorize the Department of Retirement Systems to deduct medical, dental (if elected), and vision (if elected) premiums, retiree term life insurance (if elected), and applicable premium surcharges I am required to pay from my retirement pension. I understand that deductions are taken at the end of the month that I receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.

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

Subscriber's last name

H U S K Y

Social Security number

1 2 3 - 4 5 - 6 7 8 9

9 Subscriber agreement

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans or premiums paid on my behalf. My dependents and I may also lose PEBB health plan coverage as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of PEBB insurance benefits.

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

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

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

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

If I choose to defer medical, dental, or vision for myself, I cannot enroll my eligible dependents. I understand I can enroll or reenroll no later than 60 days after losing other qualifying medical coverage or during the PEBB Program's annual open enrollment as long as I maintain and provide proof of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, as well as between each enrollment in qualifying coverages during the deferral period. A retiree or survivor enrolled in Medicare who defers enrollment while living outside of the United States will have the opportunity to enroll in a PEBB health plan by submitting the required form and proof of enrollment in Medicare Part A and Part B within the HCA required enrollment timeframe. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or no later than the last day of the PEBB Program's annual open enrollment.

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

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

If I am electing to enroll in a Medicare Advantage with Part D (MAPD) plan or the UMP Classic Medicare with Part D (PDP) plan, I certify that I have read and understand the Statement of Understanding in Section 12. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage with Part D contract. I understand that enrollment in a MAPD or UMP Classic Medicare with Part D (PDP) plan may not be retroactive. If I elect to enroll in a Kaiser Permanente MAPD plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser Permanente plan during the gap month(s) prior to when Kaiser Permanente MAPD coverage begins. If I elect to enroll in a UnitedHealthcare MAPD or UMP Classic Medicare with Part D (PDP) plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic coverage during the gap month(s) prior to when the UnitedHealthcare MAPD plan or UMP Classic Medicare with Part D (PDP) plan begins.

This form cannot be signed more than 90 days before the effective date of this coverage. (See Statement of Understanding in Section 12 for coverage effective date.)

This form replaces all election or change forms previously submitted to the PEBB Program. If I am a retiree or survivor receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with DRS to better serve me.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my insurance coverage selections being rejected or defaulted.

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

10 Signature

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

Subscriber signature

Date: 0 6 / 0 1 / 2 0 2 5

Spouse or SRDP signature (only if enrolling in a Medicare Advantage with Part D or UMP Classic Medicare with Part D (PDP) plan)

Date

Dependent signature (only if enrolling in a Medicare Advantage with Part D or UMP Classic Medicare with Part D (PDP) plan)

Date

11 Form return

Submit form and documentation using one of the methods below:

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

Fax to: 360-725-0771
Secure message: Send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

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

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

12 Medicare Advantage and UMP Classic Medicare with Part D (PDP) agreement

We offer four Medicare Advantage with Part D plans: Kaiser Permanente of the Northwest Senior Advantage with Part D (MAPD), Kaiser Permanente of Washington Medicare Advantage Plan with Part D (MAPD), UnitedHealthcare PEBB Balance, and UnitedHealthcare PEBB Complete. We also offer UMP Classic Medicare with Part D (PDP). **If you are not enrolling in one of these plans, skip this section.**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) plan I have selected in Section 4 of this form, as long as this form is signed prior to the effective date, all medical services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) when required will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

I understand that I can be a member of only one Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) at any time. By enrolling in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) 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 with Part D plan or UMP Classic Medicare with Part D (PDP), I authorize CMS to provide information to the Medicare Advantage plan or UMP Classic Medicare with Part D (PDP). 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 with Part D plan's or UMP Classic Medicare with Part D (PDP) 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 Kaiser Permanente Medicare Advantage with Part D 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 with Part D plan or UMP Classic Medicare with Part D (PDP) by sending a written request to the PEBB Program with *Form D*. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage with Part D plan providers.

I understand that as a member of the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected is effective the day PEBB insurance coverage 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, then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the PEBB Program will send me written notice of my effective date of enrollment. I understand that when my coverage begins I must get all of my medical (and prescription drug, if applicable) benefits from the plan. **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 with Part D plan or UMP Classic Medicare with Part D (PDP) identification card. Until you receive your Medicare Advantage with Part D or UMP Classic Medicare with Part D (PDP) 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 with Part D organization or UMP Classic Medicare with Part D (PDP) provides the member, prior to the effective date, evidence of health insurance coverage so they may begin using the plan services as of the effective date of enrollment.

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

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and UnitedHealthcare are Medicare Advantage with Part D plans, and UMP Classic Medicare with Part D (PDP) are Employer Group Waiver Plans and have contracts with the federal government. Enrollment depends on contract renewal.

2025 PEBB Retiree Election Form (form A)

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

Medicare Advantage with Part D plan and UMP Classic Medicare with Part D (PDP) enrollment supplemental demographic information

Providing this demographic information is **optional** and will not affect your enrollment.

Preferred language other than English

- ☐ Spanish
- ☐ Other (please indicate) :
- ☐ No selected preference

Preferred accessible format

- ☐ Braille
- ☐ Large print
- ☐ Audio CD
- ☐ No selected preference

Subscriber

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ Not of Hispanic, Latino/a, or Spanish origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Which of the following best describes you? Select all that apply.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander
- ☐ A race/ethnicity not listed
- ☐ I choose not to answer

Spouse or SRDP

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ Not of Hispanic, Latino/a, or Spanish origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Which of the following best describes you? Select all that apply.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander
- ☐ A race/ethnicity not listed
- ☐ I choose not to answer

Dependent

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ Not of Hispanic, Latino/a, or Spanish origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Which of the following best describes you? Select all that apply.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander
- ☐ A race/ethnicity not listed
- ☐ I choose not to answer

Subscriber's last name: H U S K Y

Social Security number: 1 2 3 - 4 5 - 6 7 8 9

PEBB Program contractors

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

Medical

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2023
1-800-813-2000 (TRS: 711)
Medicare members: 1-877-221-8221
TRS: 711

Kaiser Foundation Health Plan of Washington
2715 Naches Ave SW
Renton, WA 98057
1-866-648-1928, TTY: 1-800-833-6388
Medicare Advantage with Part D:
1-888-901-4600

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

Uniform Medical Plan, administered by Regence BlueShield (for medical benefit questions)
PO Box 1106
Lewiston, ID 83501-1106
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by ArrayRx (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0327
1-833-599-8539 (TRS: 711)

UnitedHealthcare
Customer Service Department
185 Asylum Ave
Hartford, CT 06103
1-855-873-3268

Dental

DeltaCare, administered by Delta Dental of Washington
400 Fairview N, Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview N, Suite 800
Seattle, WA 98109-5371
1-800-537-3406
TTY: 1-800-833-6384

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-433-6825 (TRS: 711)

Life insurance

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

Vision

Davis Vision by MetLife, underwritten by Metropolitan Life Insurance Company
Vision Care Processing Unit
200 Park Avenue
New York, NY 10166
1-888-496-4275
TTY: 1-800-523-2847

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company
1209 Orange Street
Wilmington, DE 1801
1-800-699-0993
TTY: 1-844-230-6498

Metropolitan Life Insurance Company (Vision Plan)
200 Park Avenue
New York, NY 10166
1-866-548-7139
TTY: 1-800-428-4833