Group Medicare Supplement Enrollment Application Washington State Health Care Authority

PO Box 327, MS 295
Seattle, WA 98111-9220
800-752-6663
Fax: 425-918-5278

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

You can become a Washington State Health Care Authority Medicare Supplement member if you:

- Are eligible for the group's Medicare supplement plan
- Currently have both Medicare Part A and Part B, and
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

For Office Use Only
Group Number:
_____
Effective Date of Coverage:
_____ / _____ / _____
Enrollee Class (if applicable):

Please type your answers or print clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions, incomplete answers, or the use of correction fluid or tape will result in the return of your application and may cause a delay in the effective date of your coverage.

A Personal Information

Applicant
I am eligible for Medicare Part A and B because: ◉ Age 65+ ○ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Last Name	Suffix	First Name	Middle Initial
Husky		Harry	

Home Address (cannot be a PO Box or business address)	City	County	State	Zip
123 Main Street	Seattle	King	WA	98119
Mailing Address (if different from above)	City	County	State	Zip
Billing Address (if different from both above)	City	County	State	Zip

Phone Number	Alternate Phone Number
(206) 543-4444	

Email Address*	Birthdate (Month/Day/Year)	Gender
HHUSKY@EMAIL.COM	05/01/1955	◉ Male ○ Female

*Important Note (state resident only): *We can send enrollment notifications, information about how to use your plan, and a copy of this application to you by email instead of a paper copy.*
Do you want to receive enrollment notifications, information about how to use your plan, and a copy of this application to you by email?

☐ Yes ☉ No

Race (Optional)

Premera is committed to serving the diverse needs of all our members. These fields are completely optional. If you'd like to self-identify, please do so. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

☐ America Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Two or more races
☐ Other race

Ethnicity (Optional)

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If your proficient in the English language, as well as others, please select English from the list. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

☐ Arabic	☐ Chinese	☉ English	☐ French/Haitian Creole French
☐ German	☐ Greek	☐ Italian	☐ Japanese
☐ Korean	☐ Polish	☐ Portuguese	☐ Russian
☐ Spanish	☐ Tagalog	☐ Vietnamese	☐ Other: _____

ATTENTION:
Only answer this next section if applying for PEBB retiree coverage.
Don't fill out this dependent section if you are applying for Washington state resident coverage.

Dependent (PEBB retiree only)

I am eligible for Medicare Part A and B because: ◉ Age 65+ ○ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Relationship to applicant: Spouse

Last Name	Suffix	First Name	Middle Initial
Husky		Mary	

Home Address (cannot be a PO Box or business address)	City	County	State	Zip
123 Main Street	Seattle	King	WA	98119
Mailing Address (if different from above)	City	County	State	Zip
Billing Address (if different from both above)	City	County	State	Zip

Phone Number	Alternate Phone Number
(260) 543-4444	

Email Address	Birthdate (Month/Day/Year)	Gender
MHUSKY@EMAIL.COM	03/01/1955	○ Male ◉ Female

Race (Optional)

Premera is committed to serving the diverse needs of all our members. These fields are completely optional. If you'd like to self-identify, please do so. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

☐ America Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Two or more races

☐ Other race

Ethnicity (Optional)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If your proficient in the English language, as well as others, please select English from the list. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

☐ Arabic	☐ Chinese	◉ English	☐ French/Haitian Creole French
☐ German	☐ Greek	☐ Italian	☐ Japanese
☐ Korean	☐ Polish	☐ Portuguese	☐ Russian
☐ Spanish	☐ Tagalog	☐ Vietnamese	☐ Other: _____

B Plan Selection

Which Medicare Supplement plan do you want to enroll in?

☑ Plan G

All covered family members must enroll in the same plan.

C Medicare Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions:**

Applicant

To the best of your knowledge:

- ☐ Y ☑ N 1. Did you turn 65 in the last 6 months?
- ☐ Y ☑ N 2. Will you turn 65 in the next 6 months?
- ☑ Y ☐ N 3. Did you enroll in Medicare Part B in the last 6 months?

Medicare Number (11 alphanumeric characters as seen in the image above)	
xxxxxxxxxx	
Hospital (Part A) Effective Date	Medicare (Part B) Effective Date
05/01/2000	07/01/2025

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

Dependent

To the best of your knowledge:

- ☐ Y ☑ N 1. Did you turn 65 in the last 6 months?
- ☐ Y ☑ N 2. Will you turn 65 in the next 6 months?
- ☑ Y ☐ N 3. Did you enroll in Medicare Part B in the last 6 months?

Medicare Number (11 alphanumeric characters as seen in the image above)	
xxxxxxxxxxx	
Hospital (Part A) Effective Date	Medicare (Part B) Effective Date
03/01/2000	07/01/2025

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

D Other Healthcare Information

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Applicant

1. Tell us about any help you receive from your state's Medicaid program (required):

☐ Y	☉ N	a. Are you covered for any medical assistance through the state Medicaid program? Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.
☐ Y	☉ N	b. If yes, will Medicaid pay your premiums for this Medicare Supplement plan?

☐ Y ☒ N

c. Have you recently lost coverage for medical assistance through the state Medicaid program?

If yes, when did it end? _____

2. Tell us about your Medicare Supplement coverage (required):

☐ Y ☒ N

a. Do you have another Medicare Supplement policy in force? If so, with what company, and what plan do you have?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number:

_____

☐ Y ☐ N

b. If so, do you intend to replace your current Medicare Supplement policy with this plan?

3. Tell us about your Medicare Advantage coverage (required):

☐ Y ☐ N

a. If you've had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave end date blank.

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

☐ Y ☒ N b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

☐ Y ☒ N c. Was this your first time in this type of Medicare plan?

☐ Y ☒ N d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. Tell us about any other group or individual health insurance coverage (required):

☒ Y ☐ N a. Have you had coverage under any other health insurance within the past 63 days? For example, an employer, union, or individual plan.

If so, with what company, and what kind of policy?

Company & plan type: PEBB Employer Group Medical

Member ID: _____

Start date: 01/01/1995 End date: 06/30/2025

Customer Service Phone Number:
(800) 200-1004

ATTENTION:
Only answer this next section if applying for PEBB retiree coverage.
Don't fill out this dependent section if you are applying for Washington state resident coverage.

Dependent

1. Tell us about any help you receive from your state's Medicaid program (required):

☐ Y ☒ N a. Are you covered for any medical assistance through the state Medicaid program?

Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

☐ Y ☒ N b. If yes, will Medicaid pay your premiums for this Medicare Supplement plan?

☐ Y ☒ N c. Have you recently lost coverage for medical assistance through the state Medicaid program?

If yes, when did it end? _____

2. Tell us about your Medicare Supplement coverage (required):

☐ Y ☒ N a. Do you have another Medicare Supplement policy in force? If so, with what company, and what plan do you have?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number:

_____

☐ Y ☒ N b. If so, do you intend to replace your current Medicare Supplement policy with this plan?

3. Tell us about your Medicare Advantage coverage (required):

☐ Y ☒ N

a. If you've had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave end date blank.

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

☐ Y ☒ N

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

☐ Y ☒ N

c. Was this your first time in this type of Medicare plan?

☐ Y ☒ N

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. Tell us about any other group or individual health insurance coverage (required):

☒ Y ☐ N

a. Have you had coverage under any other health insurance within the past 63 days? For example, an employer, union, or individual plan.

If so, with what company, and what kind of policy?

Company & plan type: PEBB Employer Group Medical

Member ID: _____

Start date: 01/01/1995 End date: 06/30/2025

Customer Service Phone Number:
(800) 200-1004

E Authorization and Verification of Information

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true. I understand coverage is available to me due to: (1) my residing in Washington. (2) my enrollment in Medicare Parts A and B, (3) my eligibility for Medicare due to age (65 or over), and (4) I don't receive Medicaid assistance other than payment of my Medicare Part B premium. I understand and agree that coverage does not begin until Premera accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize Premera, at its option, to pay providers directly for services rendered. I also understand and agree that Premera may:

1. Accept this application; or
2. Deny this application, in which case any subscription charges submitted will be refunded to, and accepted by me; or
3. Within the first two years of my coverage, void my contract (in other words, cancel my coverage back to its effective date, as if never existed at all) if I have made any intentionally false or misleading statements on this application or enrollment form that are material enough to affect my acceptability for coverage.

I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated in its contract with me. If Premera discloses my personal information for any other reason, Premera will first remove any data that can be used to easily identify me or will get my signed authorization.

I further understand that any physician, healthcare provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator may disclose my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera or its representatives as allowed by law.

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 insurance benefits.

I understand I am responsible for canceling any prior coverage.

If you answered yes to questions 2 or 3 in Section D, you must complete and sign the attached replacement notice.

☐ I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.

I have read all the information and have answered all questions to the best of my ability.

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Signature of applicant	Today's date
X	06/01/2005

Signature of dependent	Today's date
X	06/01/2005

Please Note: If you have a Medicare supplement or Medicare Advantage policy today (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete the "Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage" form.

If you have any questions, please contact your benefit department or Premera at 1-800-817-3049 or TDD for the Deaf or Hard of Hearing at 1-800-842-5357.

IMPORTANT: Be sure to return the entire application!

Continue to the next page for the Replacement Notice

Who Is Eligible For Coverage?

Public Employees Benefit Board (PEBB) Program Retirees, Survivors, or PEBB Continuation Coverage (COBRA) Subscribers

To be eligible, you must be an eligible retiree, survivor, or PEBB continuation coverage (COBRA) subscriber and enroll during one of the periods listed below:

- Upon initial enrollment in PEBB insurance coverage.
- Within six months of initial enrollment in Medicare Part B.
- If you deferred PEBB retiree health plan coverage, you may enroll during any PEBB Program annual open enrollment or no later than 60 days after the date other qualified coverage ends.
- Existing PEBB subscribers may change their coverage by applying for another plan during a PEBB Program annual open enrollment or a special open enrollment period, established by the PEBB Program.
- During other enrollment periods, if any, established by the PEBB Program.

Dependents of PEBB Program Retirees or PEBB Continuation Coverage (COBRA) Subscribers

To be eligible, you must be an eligible spouse or state-registered domestic partner and enroll during one of the periods listed below:

- At the same time as the PEBB retiree or PEBB Continuation Coverage (COBRA) subscriber.
- Within six months of initial enrollment in Medicare Part B.
- During a PEBB Program annual open enrollment or a special open enrollment period established by the PEBB Program.

State Residents

To be eligible, you must be a current Washington State resident and enroll during one of the periods listed below:

- No earlier than 30 days before you become eligible for Part A and Part B of Medicare.
- Within six months of initial enrollment in Medicare Part B provided that you are replacing a health plan with no lapse in coverage of more than 63 days.
- Within six months of attaining age 65 or older and is enrolled in Medicare Part B.
- Within 63 days of establishing Washington State residency. Residency date: _____
- Within 63 days of losing coverage under a retiree group health plan, a Medicare Advantage plan, a health care prepayment plan, a Program of All-Inclusive Care for the Elderly, a Medicare supplement or Medicare SELECT plan, or a Medicare risk or cost plan for reasons that qualify under federal law. Your answers in section C of the application will determine if you qualify.
- When replacing coverage or enrolling during a guaranteed issue period, as allowed by law. Your answers in section C of the application will determine if you qualify.

Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage

PO Box 327, MS 295
Seattle, WA 98111

PREMERA | BLUE CROSS

APPLICANT LAST NAME FIRST NAME SUBSCRIBER ID NUMBER

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a contract to be issued by Premera Blue Cross. Your new contract will provide (30) days within which you may decide, without cost, whether you desire to keep the contract.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this contract.

STATEMENT TO THE APPLICANT

We have reviewed your currrent medical or health insurance coverage. To the best of our knowledge, this Medicare supplement contract will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.

The replacement contract is being purchased for the following reason(s) (please check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ Disenrollment from a Medicare Advantage plan.
  Please explain reason for disenrollment: _____
- ☐ Other (please specify): _____

State law provides that your replacement contract or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods in the new contract to the extent such time was spent (depleted) under original policy.

AFTER THE APPLICATION HAS BEEN COMPLETED AND BEFORE YOU SIGN IT, REVIEW IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.

Do not cancel your present policy until you have received your new contract and are sure that you want to keep it.

APPLICANT'S SIGNATURE	DATE

Send original to Premera Blue Cross, PO Box 327, MS 295 Seattle, WA 98111

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທ່ເໝາະສົມແບບບ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

PREMERA | BLUE CROSS