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Clear form

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2021 PEBB Retiree Election Form

Complete this form to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage. If you wish to make a change to an existing retiree account, please use the *2021 PEBB Retiree Change Form* (form E). All forms and documents mentioned, and a self-paced tutorial for form A, are available on HCA's website at **hca.wa.gov/pebb-retirees**.

Remember to read and sign Section 7. To enroll dependents, fill out Section 8 starting on page 11. This form replaces all retiree enrollment/change forms submitted in the past.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in dark ink and use all capital lettering in the spaces provided.

Example: J O H N

Required — Retiree, employee, or school employee information only

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

Retiree, employee, or school employee last name: HUSKY

Social Security number: 123 45 6789

Retirement plan: DRS PLAN NAME EX PERS 2

Retirement date (or separation date for plan 3 or higher-education retirement plans): 07 01 2021

Check one:

- [x] **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. You only need to complete Sections 1 and 7 of this form. See the *2021 PEBB Retiree Enrollment Guide* for details about deferring.
- [ ] **Enrolling after deferring:** Date other qualifying medical coverage ended ____
  You must provide proof of your continuous enrollment in other qualifying coverages since your date of deferral with this form.
- [ ] **Separating:** Eligible under Plan 3 or a higher-education retirement plan separating as of ____

For new nonrepresented employees of a Washington State educational service district who are retiring:

Educational Service District (ESD) ____

When does your current health plan coverage through your ESD, COBRA, or continuation coverage end? ____

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

1 Subscriber

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

Date of birth: 0 5 0 1 1 9 5 0

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

Last name: H U S K Y

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

First name: H A R R Y

Middle initial: T

Suffix:

Phone number: 2 0 6 5 4 3 4 4 4 4

Alternate phone number:

Street address: 1 2 3 M A I N S T R E E T

Address line 2:

City: S E A T T L E

State: W A

ZIP/Postal code: 9 8 1 1 9

County: K I N G

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 from Medicare card: 0 5 0 1 2 0 1 5

Part B (medical) ✓ Yes ☐ No If Yes, enter effective date from Medicare card: 0 7 0 1 2 0 2 1

If **yes,** proof is required. Attach a copy of all pages of your entitlement letter or a copy of your Medicare card to this form if we don't already have a copy. If you are eligible for Medicare, you must enroll and stay enrolled in both Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Are you enrolled in Medicare Part D (prescription drug coverage)?

☐ Yes ✓ No If Yes, effective date:

If **yes,** you may enroll only in one of the UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans or Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Are you enrolled in Medicaid with Medicare Part D?

☐ Yes ✓ No If Yes, effective date:

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**.

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Subscriber's last name: H U S K Y

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

I wish to...

Enroll: (Check all that apply.)

Medical only Medical and dental Retiree term life insurance

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 start and end dates).

Date other qualifying coverage ended:

If deferring or enrolling after deferring, check all the boxes below that apply to you.

Enrolled as a dependent in a health plan sponsored by the PEBB Program, a Washington State educational service district, or the School Employees Benefits Board (SEBB) Program. This includes coverage 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 and 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.

The premium surcharges only apply to subscribers who are not enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The PEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the PEBB Program Administrative Policy 91-1 at **hca.wa.gov/pebb-rules**.

If you check Yes or do not check any boxes below, you will be charged the $25 premium surcharge. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* available on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

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 *PEBB Premium Surcharge Attestation Help Sheet*.

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)

List an eligible spouse or state-registered domestic partner (SRDP), as defined by Washington Administrative Code 182-12-109, you wish to cover. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time. To enroll children, please complete Section 8 at the end of this form.

Relationship to subscriber

✓ Spouse: date of marriage 0 8 0 1 1 9 8 5

Non-Medicare subscribers: If enrolling a spouse, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. A list of documents we will accept to verify their eligibility is available on HCA's website at **hca.wa.gov/pebb-retirees**.

☐ SRDP: date registered

All subscribers: If enrolling a SRDP, please attach proof of eligibility and a *2021 PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b).

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

Date of birth: 0 3 0 1 1 9 5 0

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

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

Last name: H U S K Y

First name: M A R Y

Middle initial:

Suffix:

Phone number: 2 0 6 5 4 3 4 4 4 4

Alternate phone number:

Street address (if different from subscriber's):

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: 0 3 0 1 2 0 1 5

Part B (medical) ✓ Yes ☐ No If Yes, enter effective date from Medicare card: 0 7 0 1 2 0 2 1

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

Is this person enrolled in Medicare Part D (prescription drug coverage)?

☐ Yes ✓ No If Yes, effective date:

If **yes**, you may enroll only in one of the UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans or Premera Blue Cross Medicare Supplement Plan G.

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****.*

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Subscriber's last name: H U S K Y

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

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☑ No If Yes, effective date:

The premium surcharges only apply to subscribers who are not enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. **If you check Yes or do not check any boxes below, you will be charged the $25 premium surcharge.** See the *2021 PEBB Premium Surcharge Attestation Help Sheet* available on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

☑ 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. This person has used tobacco products 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 noted in the *2021 PEBB Premium Surcharge Attestation Help Sheet*.

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 your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic.

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

☑ I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

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

If you check YES below or do not check any boxes below, you will be charged the $50 premium surcharge. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

☐ **No,** I am not subject t o the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *PEBB Spousal Plan Calculator* online. Which questions, if any, on the *PEBB Premium Surcharge Attestation Help Sheet* did you check NO? **Check all that apply.** Question 1 is not applicable.

☐ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

☐ The PEBB Program to help determine if the premium surcharge applies. I used the *PEBB Premium Surcharge Attestation Help Sheet* and 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 Medical plan selection

Kaiser Foundation Health Plan of the Northwest[1]

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

Kaiser Foundation Health Plan of Washington[1]

- [ ] Kaiser Permanente WA Classic[7]
- [ ] Kaiser Permanente WA Consumer-Directed Health Plan[5]
- [x] Kaiser Permanente WA Medicare Plan[3,4]
- [ ] Kaiser Permanente WA SoundChoice[6, 7]
- [ ] Kaiser Permanente WA Value[7]

Premera Blue Cross

- [ ] Medicare Supplement Plan G[8]

Uniform Medical Plan (UMP), administered by Regence BlueShield

- [ ] UMP Classic
- [ ] 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[9]

- [ ] UnitedHealthcare PEBB Balance
- [ ] UnitedHealthcare PEBB Complete

! Contact the plans with questions about benefits and provider information. (Contact information is on page 7 of this form.)

1 These plans have specific service areas. If you move out of the service area, you must change your plan. Otherwise, you will have limited access to network providers and covered services. You must notify the PEBB Program 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 These Medicare plans are available only in certain counties. See "Medical plans available by county" on HCA's website at **hca.wa.gov/pebb-retirees.** Submit Form C with this form if you live in a county where a Medicare Advantage plan is available.

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 Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

7 Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.

8 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.

9 Also submit Form C to enroll in these plans. They are only available to Medicare members. Any non-Medicare members on your account will 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

4 Dental plan selection

You must enroll in medical coverage to enroll in dental. If you enroll in dental, 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 (WAC 182-12-208). However, you may change dental plans within those two years.

Preferred Provider Organization (PPO)

- [x] **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. Before you enroll, call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.

- [ ] **Willamette Dental of Washington, Inc.** (Group WA82), administered by Willamette Dental Group. You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

5 Retiree term life insurance

Retiree term life insurance is available only if you receive 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. To apply for retiree term life insurance, submit the *2021 PEBB MetLife Enrollment/Change Form for Retiree Plan* (including beneficiary designation) to the PEBB Program with this form.

- [ ] I acknowledge that I have completed the PEBB MetLife Enrollment/Change form for Retiree Plan and will return it with this form.

Subscriber's last name: H U S K Y

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

6 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 the 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. We will not enroll you in coverage until we receive your first payment. 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 payment is needed. Due to timing issues with the Department of Retirement Systems, a first payment may be required for premiums and applicable premium surcharges that were not deducted from your pension. If you receive an invoice, you must pay by check until your pension deduction is set up.

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.

How would you like to pay your medical, dental, and life insurance premiums (if elected) and applicable premium surcharges?

☐ **Electronic Debit Service (EDS):** I will pay my monthly medical and dental premiums (if elected) and applicable premium surcharges by EDS. I will submit the *2021 PEBB Electronic Debit Service Agreement* available in the *Retiree Enrollment Guide*. 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 and dental premiums (if elected), retiree term life insurance (if elected), and 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.

☐ **Invoicing:** I will pay my medical and dental premiums (if elected) 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

7 Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health 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 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, I must stay enrolled in retiree dental for at least two years unless I terminate or defer PEBB retiree health plan 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 eligible for Medicare Part A and Part B, we must enroll and stay 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 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 Program rules.

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 *2021 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.

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 signature: Husky

Date: 0 6 1 0 2 0 2 1

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

Electronically submit: Send a secure online message to PEBB Customer Service by registering for an account on HCA's website at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

HCA is committed to providing equal access to our services. If you need an accommodation, please call the PEBB Program at 1-800-200-1004.

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**.

Subscriber's last name | Social Security number

2021 PEBB Program contractors

Do not send forms to the addresses below. This information is for reference only.

Medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St.
Suite 3100
Seattle, WA 98101-1374
1-866-648-1928 (TTY: 1-800-833-6388)

Premera Blue Cross
PO Box 327
Seattle, WA 98111-0327
1-800-817-3049 (TTY: 1-800-842-5357)

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

Uniform Medical Plan, administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

UnitedHealthcare
Customer Service Department
PO Box 30770
Salt Lake City, Utah 84130-0770
1-855-873-3268

Dental contractors

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

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 (TTY: 711)

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

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Subscriber's last name: H U S K Y

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

8 Dependents

List eligible 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. Use additional forms for more dependents.

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

Subscribers who are not enrolled in Medicare Part A and Part B must provide proof of eligibility for each dependent within the PEBB Program's enrollment timelines or the dependent will not be enrolled. A list of documents we will accept to verify dependent eligibility is available on HCA's website at **hca.wa.gov/pebb-retirees**.

If enrolling a state-registered domestic partner's child or an extended dependent, also attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, also attach a *2021 PEBB Extended Dependent Certification*.

If enrolling a child with a disability age 26 or older, also attach a *2021 PEBB Certification of a Child with a Disability* and return as instructed on the form. Visit HCA's website at **hca.wa.gov/pebb-retirees** for eligibility information.

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)

Address line 2

City

State

ZIP/Postal code

County

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**.

2021 PEBB Retiree Election Form

Subscriber's last name: H U S K Y

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

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:

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

Is this person enrolled in Medicare Part D (prescription drug coverage)?

☐ Yes ☐ No If Yes, effective date:

If **Yes**, you may enroll only in one of the UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans or Premera Blue Cross Medicare Supplement Plan G.

Is this person enrolled in Medicaid with Medicare Part D?

☐ Yes ☐ No If Yes, effective date:

The premium surcharges only apply to subscribers who are not enrolled in Medicare Part A and Part B.

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.** See the *2021 PEBB Premium Surcharge Attestation Help Sheet* available on HCA's website at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

☐ 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. This person has used tobacco products 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 noted in the *2021 PEBB Premium Surcharge Attestation Help Sheet*.

Use additional forms to list more dependents.

C

2021 **PEBB Medicare Advantage Plan Election Form**

Please fill in all information requested. Be sure to read and sign section 5 on page 5 of this form.
Type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example: J O H N
Inaccurate, incomplete, or illegible information may delay coverage. The information written on this form replaces all enrollment forms previously submitted.

1 Retiree

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

Date of birth: 0 5 0 1 1 9 5 0

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

Last name (as it appears on Medicare card): H U S K Y

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

First name: H A R Y

Middle initial: T

Suffix:

Phone number: 2 0 6 5 4 3 4 4 4 4

Alternate phone number:

Street address (required): 1 2 3 M A I N S T R E E T

Address line 2:

City: S E A T T L E

State: W A

ZIP/Postal code: 9 8 1 1 9

County: K I N G

Mailing address (if different):

Mailing address line 2:

City:

State:

ZIP/Postal code:

County:

Retiree Medicare number: 1 2 3 4 5 6 7 8 9 A

Are you entitled to Medicare Part A or Part B?

Part A (hospital) ✓ Yes Effective date 0 5 0 1 2 0 1 5 ☐ No

Part B (medical) ✓ Yes Effective date 0 7 0 1 2 0 2 1 ☐ No

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**.

2021 PEBB Medicare Advantage Plan Election Form

Retiree's last name: H U S K Y

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

Married — Date: 0 8 / 0 1 / 1 9 8 5

State-registered domestic partnership/legal union — Date:

Retiree medical information

Your answer to question 3 will not affect your eligibility to enroll in a Medicare Advantage plan.

1. **Do you have any health insurance other than Medicare?** Yes No

   If yes, through which carrier?

   P E B B E M P L O Y E R C O V E R A G E

   What type of policy?

   G R O U P M E D I C A L P L A N

   Do you intend to discontinue this policy? Yes No

2. **Do you live in an institution?** Yes No

   If yes, name of institution

   Phone number

   Address

3. **Are you currently receiving Medicaid?** Yes No

   If yes, Medicaid number

2021 PEBB Medicare Advantage Plan Election Form

Retiree'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

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

Date of birth: 0 3 0 1 1 9 5 0

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

Last name (as it appears on Medicare card): H U S K Y

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

First name: M A R Y

Middle initial

Suffix

Street address (if different from subscriber's)

Address line 2

City

State

ZIP/Postal code

County

Spouse or SRDP's Medicare number: 9 8 7 6 5 4 3 2 1 A

Is this person entitled to Medicare Part A or Part B?

Part A (hospital) ✓ Yes Effective date 0 3 0 1 2 0 1 5 ☐ No

Part B (medical) ✓ Yes Effective date 0 7 0 1 2 0 2 1 ☐ No

Spouse or SRDP medical information

! Your answer to question 3 will not affect your eligibility to enroll in a Medicare Advantage plan.

1. **Do you have any health insurance other than Medicare?** ✓ Yes ☐ No

   If yes, through which carrier?
   P E B B E M P L O Y E R C O V E R A G E

   What type of policy?
   G R O U P M E D I C A L P L A N

   Do you intend to discontinue this policy? ☐ Yes ✓ No

2. **Do you live in an institution?** ☐ Yes ✓ No

   If yes, name of institution

   Phone number

   Address

3. **Are you currently receiving Medicaid?** ☐ Yes ✓ No

   If yes, Medicaid 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**.

2021 PEBB Medicare Advantage Plan Election Form

Retiree's last name: H U S K Y

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

3 Plan choice

Kaiser Foundation Health Plan of the Northwest

- [ ] Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington

- [x] Kaiser Permanente WA Medicare Advantage

UnitedHealthcare

- [ ] UnitedHealthcare PEBB Balance
- [ ] UnitedHealthcare PEBB Complete

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.

Name of retiree's contracting primary care provider (refer to plan's provider directory): D R J O H N W U

Current patient? [x] Yes [ ] No

Name of spouse's or SRDP's contracting primary care provider (refer to plan's provider directory): D R J O H N W U

Current patient? [x] Yes [ ] No

2021 PEBB program medical contractors

Do not send forms to the addresses below. This information is for reference only.

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
1-877-221-8221 (TTY: 711)

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

UnitedHealthcare
PO Box 30770
Salt Lake City, UT 84130-0770
1-855-873-3268 (TRS: 711)

Retiree's last name: H U S K Y

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

5 Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state 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. Penalties include 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.)

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

Signature of retiree: Husky

Date: 0 6 1 0 2 0 2 1

Signature of spouse or SRDP (if enrolling): Husky Spouse

Date: 0 6 1 0 2 0 2 1

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

Electronically submit: Send a secure online message to PEBB Customer Service by registering for an account on HCA's website at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

6 Authorized representative

! If you are the authorized representative, read and sign below and provide the following information.

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.

Signature of authorized representative

Date

Name

Relationship to retiree

Address

Phone

HCA is committed to providing equal access to our services. If you need an accommodation, please call us at 1-800-200-1004.

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**.

6 Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected in section 3 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 they 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 the Northwest, Kaiser Foundation Health Plan of Washington, and UnitedHealthcare are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.