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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: HERP / HIGHER EDUCATION RET PLAN

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

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. 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: 123-45-6789

Date of birth: 05/01/1950

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

Last name: HUSKY

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

First name: HARRY

Middle initial: T

Suffix:

Phone number: 206-543-4444

Alternate phone number:

Street address: 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 from Medicare card: 05/01/2015

Part B (medical) ✓ Yes ☐ No If Yes, enter effective date from Medicare card: 07/01/2021

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: 07/01/2021

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: HUSKY

Social Security number: 123 45 6789

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 08 01 1985

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: 987 65 4321

Date of birth: 03 01 1950

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

Last name: HUSKY

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

First name: MARY

Middle initial:

Suffix:

Phone number: 206 543 4444

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: 03 01 2015

Part B (medical) ✓ Yes ☐ No If Yes, enter effective date from Medicare card: 07 01 2021

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: 07 01 2021

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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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.

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.

☐ **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.

☐ **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*.

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

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]
- ☐ 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)

☑ **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.

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

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**.

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

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

Subscriber's last name: HUSKY

Social Security number: 123 45 6789

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**.

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.

PREMERA BLUE CROSS

P.O. Box 91120, MS 295
Seattle, WA 98111-9220

B

Group Medicare Supplement Enrollment Application
Washington State Health Care Authority

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 PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted. PLEASE RETURN ALL THE PAGES OF THE APPLICATION EVEN IF THEY ARE BLANK.

A Your 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	First Name	Middle Initial	Social Security Number (required)
HUSKY	HARRY	T	123-45-6789

Home Address (cannot be a P.O. Box)	City	County	State	ZIP
123 MAIN STREET	SEATTLE	KING	WA	98119
Mailing Address (if different from above)	City	County	State	ZIP

Daytime Phone Number	Email Address
(206) 543-4444	

Birthdate *Month*	*Day*	*Year*	Gender
05	01	1950	■ Male ☐ Female

Dependent

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	First Name	Middle Initial	Social Security Number (required)
HUSKY	MARY		987-65-4321

Home Address (cannot be a P.O. Box)	City	County	State	ZIP
SAME AS APPLICANT				
Mailing Address (if different from above)	City	County	State	ZIP

Daytime Phone Number	Email Address
(206) 543-4444	

Birthdate *Month*	*Day*	*Year*	Gender
03	01	1950	☐ Male ■ Female

B What Plan Do You Want?

Which Medicare supplement plan do you want to enroll in? ☒ Plan G

Did you receive a copy of the Premera Blue Cross "Outline of Coverage"? ☐ Yes ■ No

Did you receive a copy of Medicare's "Choosing A Medigap Policy" guide? ☐ Yes ■ No

C Your Other Health Coverage

Please answer all the questions below as best you know how.

Applicant

Tell Us About Your Medicare Coverage (You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ■No

b. Did you enroll in Medicare Part B in the last 6 months? ■Yes ☐No

c. If **Yes**, what is the effective date? (month and year) 07 / 01 / 2021

(See your Medicare card to find this date.)

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

Your Medicare Information Here

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

1234 - 56 - 7890 - A

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	05 / 01 / 2015
Part B Medical Insurance	07 / 01 / 2021

Tell Us About Your Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you 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)? ☐Yes ■No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)

If you are still covered under this plan, leave "End" blank.

Start: / / End: / /

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐ Yes ■ No

c. Was this your first time in this type of Medicare plan? ☐ Yes ■ No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ■ No

Tell Us About Your Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave 3.b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐ Yes ■ No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐ Yes ■ No

Tell Us About Any Other Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ■ Yes ☐ No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: PEBB EMPLOYER COV Policy: GROUP MEDICAL

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: 01 / 01 / 1990 End: 06 / 30 / 2021

Tell Us About Any Help With Your Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. 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. ☐ Yes ■ No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐ Yes ■ No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐ Yes ■ No

Dependent

Tell Us About Your Medicare Coverage
(You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ■No

b. Did you enroll in Medicare Part B in the last 6 months? ■Yes ☐No

c. If **Yes**, what is the effective date? (month and year) 07 / 01 / 2021

(See your Medicare card to find this date.)

Dependent's Medicare Information Here

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

987 - 65 - 4321 - A

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	03 / 01 / 1950
Part B Medical Insurance	07 / 01 / 2021

Tell Us About Your Dependent's Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you 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)? ☐Yes ■No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)
If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐Yes ■No

c. Was this your first time in this type of Medicare plan? ☐Yes ■No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ■No

Tell Us About Your Dependent's Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ■No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐ Yes ■ No

Tell Us About Any Other Dependent Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ■ Yes ☐ No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: PEBB EMPLOYER COV Policy: GROUP MEDICAL

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: 01 / 01 / 1990 End: 06 / 30 / 2021

Tell Us About Any Help With Your Dependent's Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. 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. ☐ Yes ■ No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐ Yes ■ No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐ Yes ■ No

Proceed to section D

D Conditions of Enrollment/Signatures

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.

1. I am an eligible member of the group.
2. I have **both** Medicare Parts A and B in force today.
3. I understand that my coverage does not start until Premera accepts this application and assigns an effective date.
4. I authorize Premera, at its option, to pay doctors and other providers directly for health care I receive.
5. 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.
6. I also understand and agree that Premera may cancel this coverage back to its start date as if I never had coverage at all, if it is found that I have supplied false information, or any information was omitted by me or for me, on this application, and that information is material enough to affect my eligibility for coverage. (Please note: After coverage has been in force for two years, coverage may no longer be canceled for this reason.)
7. 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. Examples are to determine my eligibility for enrollment or to pay claims. If Premera discloses my personal information for any other reason, Premera will first take out any data that can be used to easily identify me, or will get my signed permission.

Be sure to sign and date this application, include all pages of the application and provide any proof required for "yes" answers in section C, when submitting to Premera for processing.

Signature of Applicant	Today's Date
X Husky	06/10/2021

Signature of Dependent	Today's Date
X Husky Spouse	06/10/2021

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 Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this plan, you become entitled to Medicaid, the benefits and subscription charges under your Medicare Supplement contract 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 plan (or, if that is no longer available, a substantially equivalent plan) will be re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a “Qualified Medicare Beneficiary” (QMB) or a “Specified Low-Income Medicare Beneficiary” (SLMB).
5. 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 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.

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.

Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the 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, or sex, you can file a grievance with:
Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة.
اتصل بـ(TTY: 800-842-5357) 800-722-1471

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471
(TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese): この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 **(Korean):**
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ **(Lao):**
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ **(Khmer):**
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។
សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ **(Punjabi):**
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ .ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ .ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریقPremera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'amatalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

Clear form

PEBB **Electronic Debit Service Agreement**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

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

I am submitting this form to (check one):

✓ Start an EDS from my bank account. ☐ Change my EDS bank account.

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

1 Subscriber Information

Last name, first name

H U S K Y

PEBB account/Social Security number

1 2 3 4 5 6 7 8 9

2 Bank Account Information

Account holder's last name, first name (if different from above)

Name of financial institution

B A N K O F A M E R I C A

Branch address

4 7 0 1 U N I V E R S I T Y W A Y

City

S E A T T L E

State

W A

ZIP/Postal code

9 8 1 1 9

Account type

✓ Checking ☐ Savings

Routing number

4 4 4 5 5 5 6 6 6

Account number

9 7 6 4 3 1 2 6 1 2 3 0 0 0

3 Signature

I hereby authorize the Health Care Authority (HCA) to start electronic funds transfers from the financial institution named above. I understand my authorization remains in effect until I give written notice to HCA, which I must do at least 15 business days before my next monthly withdrawal. If I want to change the checking or savings account that HCA withdraws from, I will submit a new ***PEBB Electronic Debit Service Agreement*** form at least 15 business days before the next withdrawal. Withdrawals will occur on the 15th day of each month that I have PEBB insurance coverage, and will be in the amount of my monthly invoice. If the 15th falls on a Saturday, Sunday, or holiday, the withdrawal will occur on the next business day. HCA will notify me of payments returned for insufficient funds or closed accounts. HCA reserves the right to change or terminate this agreement as an account payment method for any reason and at any time by giving proper notice of at least 15 business days.

Signature Husky

Date 0 6 / 1 0 / 2 0 2 1

> ! This form must be signed by the bank account holder to authorize debit service.

4 Form return instructions

To complete your authorization process:

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

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

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

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

! You must continue to pay your premiums and applicable premium surcharges as invoiced until you receive a letter from HCA with your EDS start date. EDS approval takes six to eight weeks. You must submit a new ***PEBB Electronic Debit Service Agreement*** form to HCA when your bank account information changes.