Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

A

2020 PEBB Retiree Coverage Election Form

Complete this form to apply to enroll in or defer (postpone) enrollment in retiree insurance coverage. If you wish to make a change to an existing retiree account, please use the *2020 PEBB Retiree Coverage Change Form* (form E).

Remember to read and sign page 9. To enroll dependents, fill out Section 8 starting on page 10. This form replaces all retiree enrollment/change forms submitted in the past.

Type or print clearly in dark ink, use only capital block lettering inside the boxes as shown in the example. Inaccurate, incomplete, or illegible information may delay coverage.
Follow example to fill in form:

J	O	H	N

Required **Retiree or employee information only**

Retiree or employee last name

H U S K Y

Social Security number

1 2 3 4 5 6 7 8 9

Retirement plan

"Your Plan Name Here"

Retirement date

0 7 0 1 2 0 2 0

Check one:

✓ **Enrolling:** I am a new retiree or a surviving dependent applying for coverage

Deferring: I am a new retiree or a surviving dependent deferring (postponing) my coverage. Also complete Section 1 and Section 7 of this form. See the *2020 PEBB Retiree Enrollment Guide* for details about deferring.

Enrolling after deferring: Date other qualifying medical coverage ended

Separating: Eligible under Plan 3 retirement plan, separating as of

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

Educational service district

N / A

When does your current medical/dental 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.

Subscriber's last name

H U S K Y

Subscriber's Social Security number

1 2 3 4 5 6 7 8 9

Section 1 Subscriber information and enrollment

Last name

H U S K Y

Suffix

First name

H A R R Y

Middle initial

Date of birth (mm/dd/yyyy)

0 5 0 1 1 9 5 0

Social Security number

1 2 3 4 5 6 7 8 9

Sex

✓ M F

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 Code

9 8 1 1 9

County of residence

K I N G

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP Code

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

Tobacco use premium surcharge

The PEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

- **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 *2020 PEBB Premium Surcharge Attestation Help Sheet.*

Subscriber's last name: H U S K Y

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

Section 1 Subscriber information and enrollment *(continued)*

✓ **Enroll:**

Medical only ✓ Medical and dental Retiree term life insurance

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 the box(es) below that applies to you.

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

Enrolled in employer-based group medical as an employee or 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 retirees: Enrolled in qualified health plan coverage through a health benefit exchange, not including Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

Are you enrolled in Part(s) A and/or B of Medicare? 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. Write your full name and the last four digits of your Social Security number on the copy. If you are entitled to Medicare, you must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Part A (hospital) ✓ Yes No If yes, effective date 0 5 0 1 2 0 1 5

Part B (medical) ✓ Yes No If yes, effective date 0 7 0 1 2 0 2 0

Are you enrolled in Medicare Part D (prescription drug coverage)? If **Yes**, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Yes ✓ No If yes, effective date

Are you enrolled in Medicaid with Medicare Part D?

Yes ✓ No If yes, effective date

Do you receive Social Security Disability?

Yes ✓ No If yes, effective date

Subscriber's last name: H U S K Y

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

Section 2 Spouse or state-registered domestic partner information

List an eligible spouse or state-registered domestic partner, 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.

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. **All subscribers:** If enrolling a state-registered domestic partner, please attach proof of eligibility and a *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent under IRC Section 152, as modified by IRC Section 105(b). A list of documents we will accept to verify the dependent's eligibility is available at **hca.wa.gov/pebb-retirees**.

Relationship to subscriber

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

State-registered domestic partner: date registered

Last name: H U S K Y

Suffix: M R S

First name: M A R Y

Middle initial

Date of birth (mm/dd/yyyy): 0 3 0 1 1 9 5 0

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

Sex: M ✓ F

Street address (if different from subscriber)

Address line 2

City

State

ZIP Code

Is this person enrolled in Part(s) A and/or B of Medicare? 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. Write your full name and the last four digits of your Social Security number on the copy. If they are entitled to Medicare, they must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage.

Part A (hospital) ✓ Yes No

If yes, effective date 0 3 0 1 2 0 1 5

Part B (medical) ✓ Yes No

If yes, effective date 0 7 0 1 2 0 2 0

Is this person enrolled in Medicare Part D (prescription drug coverage)? If **Yes**, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. Some Plan F enrollees may stay in the plan.

Yes ✓ No

If yes, effective date

Is this person enrolled in Medicaid with Medicare Part D?

Yes ✓ No

If yes, effective date

Does this person receive Social Security Disability?

Yes ✓ No

If yes, effective date

Subscriber's last name

H U S K Y

Subscriber's Social Security number

1 2 3 4 5 6 7 8 9

Premium surcharges only apply to subscribers who are not enrolled in Medicare Part A and Part B

Tobacco use premium surcharge

The PEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check **Yes** or leave this section blank, you will be charged the $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/pebb-retirees** for instructions on how to respond.

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

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 *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if your spouse or state-registered domestic partner has chosen not to enroll in another employer-based group medical insurance that is comparable to PEBB's Uniform Medical Plan Classic. For instructions on how to respond, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/pebb-retirees**. If you check **Yes** below or leave this section blank, you will be charged the $50 premium surcharge.

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

Yes, I am subject to the $50 premium surcharge. I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 PEBB Spousal Plan Calculator* at **hca.wa.gov/pebb-retirees**.

✓ **No, I am not subject to the $50 premium surcharge.**
I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *2020 PEBB Spousal Plan Calculator*. If **No**, which questions on the *2020 PEBB Premium Surcharge Attestation Help Sheet* did you check **No** (if any)? 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 *2020 PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *2020 PEBB Spousal Plan Calculator*.

Subscriber's last name

H U S K Y

Subscriber's Social Security number

1 2 3 4 5 6 7 8 9

Section 3 Medical plan selection *See instruction sheet for more information.*

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

- Premera Blue Cross Medicare Supplement Plan G[8]

Uniform Medical Plan, administered by Regence BlueShield

- UMP Classic
- UMP Consumer-Directed Health Plan[5]
- UMP Plus—Puget Sound High Value Network[1, 5]
- UMP Plus—UW Medicine Accountable Care Network[1, 5]

[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 offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

[3] These Medicare Advantage plans are available in certain counties to Medicare enrollees. Also complete and attach Form C if you live in a county where Medicare Advantage is available.

[4] If you cover dependents not enrolled in Medicare Part A and Part B, you must also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.

[5] These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate their PEBB coverage to enroll in this plan. They will not be eligible for COBRA or other continuation coverage options.

[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] This plan is available only if at least one member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA Medicare Plan.

[8] Also submit Form B to enroll in Premera Blue Cross Medicare Supplement Plan G.

2020 PEBB Retiree Coverage Election Form

Subscriber's last name

H U S K Y

Subscriber's Social Security number

1 2 3 4 5 6 7 8 9

Section 4 Dental plan selection *See instruction sheet for more information.*

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 during the PEBB Program's annual open enrollment (November 1 through 30) or due to a special open enrollment event. Before you select a dental plan, call the plan to make sure your provider accepts the specific plan and plan group.

Preferred Provider Organization (PPO)

✓ Uniform Dental Plan (Group #3000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time.

Managed-Care Plans (limited network)

DeltaCare (Group #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network.

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.

Section 5 Retiree term life insurance election

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 *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.

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

2020 PEBB Program medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388
Medicare members: 1-888-901-4600

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

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

2020 PEBB Program dental contractors

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

Uniform Dental Plan, *administered by Delta Dental of Washington*
400 Fairview Ave. N., Suite 800
Seattle, WA 98109
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124
1-855-4DENTAL (1-855-433-6825)

2020 PEBB Program life insurance contractor

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

Subscriber's last name

H U S K Y

Subscriber's Social Security number

1 2 3 4 5 6 7 8 9

Section 6 Payment authorization *See instruction sheet for more information.*

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) no later than 45 days after your 60-day election period ends. If we do not receive your first payment by this deadline, we will not enroll you. You may lose your right to enroll in PEBB retiree insurance coverage.

How to make the first payment

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 (DRS), 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.

If you select Electronic Debit Service (EDS) or invoicing below, make your check payable to Health Care Authority. Send it with your EDS form to:

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

Pick One

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

Pension deduction: I authorize DRS to deduct medical and dental (if elected) premiums, retiree term life insurance (if elected) premiums 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. Good Option for DRS Plans Not UWRP

Electronic Debit Service (EDS): I will submit the *2020 PEBB Electronic Debit Service Agreement* available in the *2020 PEBB Retiree Enrollment Guide*. I will pay my monthly premiums and applicable premium surcharges by check until notified of my EDS effective date. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. To pay by EDS for your retiree term life insurance, contact MetLife at 1-866-548-7139.

Invoicing: I will pay my medical and dental (if elected) premiums and applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected.

Note: You cannot have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage, COBRA, or continuation coverage ended. Premiums and applicable premium surcharges are for a full month of coverage and cannot be prorated for a partial month, including when a member dies or terminates coverage before the end of the month. Payments are processed immediately as required by state law.

Continue to Section 7 to sign and complete this form. To add or remove dependents, also complete Section 8.

Questions? Visit **hca.wa.gov/pebb-retirees** or call us at 1-800-200-1004.

2020 PEBB Retiree Coverage Election Form

Subscriber's last name	Subscriber's Social Security number
H U S K Y	1 2 3 4 5 6 7 8 9

Section 7 Signature *See instruction sheet for more information.*

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 plan(s) or premiums paid on my behalf. My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company and can result in imprisonment, fines, and denial of PEBB benefits.

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

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

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

If I die, my eligible surviving dependents must complete the *2020 PEBB Retiree Coverage Election Form* (form A) to enroll or defer enrollment in PEBB retiree health plan 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 rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

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

Subscriber's signature Harry Husky Date 0 6 1 5 2 0 2 0

Please sign, date, and keep a copy for your records. Mail the completed form and documentation to the Washington State Health Care Authority, PEBB Program, PO Box 42684, Olympia, WA 98504-2684, or fax to 360-725-0771.

Subscriber's last name: H U S K Y

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

Section 8 Dependent information *See instruction sheet for more information.*

Relationship to subscriber

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

Last name | Suffix

First name | Middle initial | Date of birth (mm/dd/yyyy)

Social Security number | Sex M F

Street address (if different from subscriber)

NONE

Address line 2

City | State | ZIP Code

Is this person enrolled in Part(s) A and/or B of Medicare? If **Yes**, proof is required. Attach a copy of all pages of your dependent's entitlement letter or a copy of their Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Part A (hospital) Yes No

If yes, effective date

Part B (medical) Yes No

If yes, effective date

If your dependent is entitled to 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

Is this person enrolled in Medicaid with Medicare Part D?

Yes No

If yes, effective date

Does this person receive Social Security Disability?

Yes No

If yes, effective date

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

Tobacco use premium surcharge

Does the tobacco use premium surcharge apply to this dependent? Check one.

Yes, I am subject to the $25 premium surcharge.
This dependent has used tobacco products in the past two months.

No, I am not subject to the $25 premium surcharge.
This dependent has not used tobacco products in the past two months, or they have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

C

2020 Medicare Advantage Plan Election Form

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

Section 1: Subscriber information

Medical effective date (mm/dd/yyyy) 05/01/2015					
Social Security number 123456789	Last name (as it appears on Medicare card) Husky	First name Harry	Middle initial	Sex ☑ M ☐ F	
Permanent residential street address (required) 123 Main Street		City Seattle	State WA	ZIP Code 98119	
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code	
County of residence KING	Date of birth (mm/dd/yyyy) 05/01/1950	☑ Married (mm/dd/yyyy) 08/01/1985	☐ State-registered domestic partnership/legal union (mm/dd/yyyy)	Home phone number (with area code) 206-543-4444	

Retiree Medicare claim number from Medicare card 123456789	**Entitled to Part A (hospital)** ☑ Yes ☐ No If yes, effective date 05/01/2015
	Entitled to Part B (medical) ☑ Yes ☐ No If yes, effective date 07/01/2020

Section 2: Spouse or state-registered domestic partner information *(if applying)*

Social Security number 123456789	Last name (as it appears on Medicare card) Husky	First name Mary	Middle initial	
Permanent residential street address (required) 123 Main Street		Date of birth 03/01/1950	Sex ☐ M ☑ F	
City Seattle		State WA	ZIP Code + 4 98119	
Mailing address (if different)				
City		State	ZIP Code + 4	

Spouse or state-registered domestic partner's Medicare claim number from Medicare card 987654321	**Entitled to Part A (hospital)** ☑ Yes ☐ No If yes, effective date 03/01/2015
	Entitled to Part B (medical) ☑ Yes ☐ No If yes, effective date 07/01/2020

Section 3: Plan choice

Kaiser Foundation Health Plan of the Northwest
☐ Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington
☑ Kaiser Permanente WA Medicare Advantage

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

(continued)

Please return this form by mail to:

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

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

Signature and authorization

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

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

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

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

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

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

Signature of retiree	Date	Signature of spouse or state-registered domestic partner (if enrolling)	Date
Mary Husky	06/15/2020	Mary Husky	06/15/2020

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

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

Signature of authorized representative	**Date**

Name	**Relationship to retiree**
Address	**Phone**

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

Statement of Understanding

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

I understand that the Medicare Advantage plan will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision or coordination of benefits or to professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

*I understand that my enrollment in the Medicare Advantage plan I have selected is effective the day PEBB insurance begins, or the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during the PEBB Program's annual open enrollment (November 1-30), then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date of enrollment. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so 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 Washington and Kaiser Foundation Health Plan of the Northwest are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.

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

2020 PEBB MEDICAL CONTRACTORS

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101-1374
1-888-901-4600 or TTY: 1-800-833-6388

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

Electronic Debit Service Agreement

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 black ink.

I am submitting this form to (check one):

☒ Start an electronic debit service from my bank account.

☐ Change my electronic debit service bank account.

Subscriber's Information

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

Bank Account Information

Account holder's name (if different from above; please print)

Name of financial institution	Branch address
Bank of America	4701 University Way

City	State	ZIP Code	Bank routing number
Seattle	WA	98119	444555666

☒ Checking ☐ Savings (Check one)

Account number: 97643126

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

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

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

Signature **(Must be signed by the bank account holder to authorize debit service)**	Date
Harry Husky	06/15/2020

To complete your authorization process:

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

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

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

Remember!

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

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

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