

# 2008 Leave Without Pay (LWOP) Continuation Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- List **only** eligible family members and indicate their enrollment status.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- Attach appropriate **dependent certification** forms if required (students age 20 through age 23, extended dependents, and dependents with disabilities.) Forms are available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).

|   |  |           |  |                              |                  |
|---|--|-----------|--|------------------------------|------------------|
| <b>Section 1: SUBSCRIBER INFORMATION</b>  |  |           |  | Date employer coverage ended |                  |
| Social security number  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Last name | First name                                     | Middle initial               |                  |
| Address   |  |           |  |                              | Apt./unit number |
| City  |  | State     | ZIP Code                                       | County of residence          |                  |
| Date of birth (mm/dd/yyyy)  | Work phone number (including area code)<br>( )               |           | Home phone number (including area code)<br>( ) |                              |                  |
| Are you part-time faculty? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |           |  |                              |                  |
| Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only <input type="checkbox"/> Life insurance <input type="checkbox"/> Long-term disability (only if on educational leave) |  |           |  |                              |                  |
| <input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____  |  |           |  |                              |                  |
| Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____  |  |           |  |                              |                  |
| Note: If you are enrolled in Medicare Parts A and B, <b>attach a copy</b> of your Medicare card(s) along with this form.  |  |           |  |                              |                  |

|  |   |                |                            |  |  |
|--|---|----------------|----------------------------|--|--|
| <b>Section 2: SPOUSE OR QUALIFIED DOMESTIC PARTNER INFORMATION</b>   |   |                |                            | <i>List only eligible family members and indicate their enrollment status.</i> |  |
| Social security number   | Date of marriage or partnership established/registered (mm/dd/yyyy) |                |                            | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F                   |  |
| Last name  | First name  | Middle initial | Date of birth (mm/dd/yyyy) |  |  |
| Address (if different from subscriber)   |   | City           | State                      | ZIP Code   |  |
| Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only |   |                |                            |  |  |
| <input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____   |   |                |                            |  |  |
| Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____                   |   |                |                            |  |  |
| Note: If you are enrolled in Medicare Parts A and B, <b>attach a copy</b> of your Medicare card(s) along with this form.                                 |   |                |                            |  |  |

|   |  |   |
|---|--|---|
| <b>Qualifying event</b> <i>Check only one</i>                               |  |   |
| <input type="checkbox"/> Applying for disability retirement                 | <input type="checkbox"/> Reversion employee                | <input type="checkbox"/> Approved educational leave |
| <input type="checkbox"/> Reduction in force (RIF)                           | <input type="checkbox"/> Approved leave without pay (LWOP) | <input type="checkbox"/> Seasonal employment        |
| <input type="checkbox"/> Part-time faculty reduction in hours               | <input type="checkbox"/> Workers' compensation             | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Military leave (provide date called to duty _____) |  |   |



Visit our Web site at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)

### 2008 PEBB MEDICAL CONTRACTORS

Aetna Public Employees Plan of Washington, P.O. Box 14089, Lexington, KY 40512-4089  
Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099  
Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850

### 2008 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157  
Uniform Dental Plan, 9706 Fourth Avenue NE, Seattle, WA 98115-2157

Williamette Dental of Washington, Inc., 11241 Slater Ave. NE, Kirkland, WA 98033

**Section 3: FAMILY MEMBER INFORMATION** (Such as child, etc.) Use additional forms for more members. List only eligible family members and indicate their enrollment status..

|  |                        |   |  |
|--|------------------------|---|--|
| Relationship to subscriber             | Social security number | <input type="checkbox"/> Disabled? <input type="checkbox"/> Student?<br><i>Check only if age 20 or older.</i> | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Last name                              | First name             | Middle initial  | Date of birth (mm/dd/yyyy)                                   |
| Address (if different from subscriber) | City                   | State   | ZIP Code   |

Select coverage you wish to continue:  Medical/Dental  Medical only  Dental only  
 Cancel all coverage Reason \_\_\_\_\_ Date of qualifying event \_\_\_\_\_

Are you covered by another group medical or dental plan?  Yes  No Effective date \_\_\_\_\_

**\*Note:** If you are enrolled in Medicare Part(s) A and/or B, attach a copy of your Medicare card(s) along with this form.

|   |  |
|---|--|
| <b>Section 4: MEDICAL PLAN SELECTION</b><br><i>Check only one.</i>  | <b>Section 5: DENTAL PLAN SELECTION</b><br><i>Check only one.</i>  |
| <b>Contact plans for more information; their addresses are shown at the front of this form.</b>   |  |
| <input type="checkbox"/> Aetna Public Employees Plan of Washington<br>Group Health Cooperative<br><input type="checkbox"/> Group Health Classic<br><input type="checkbox"/> Group Health Value<br>Kaiser Foundation Health Plan of the Northwest<br><input type="checkbox"/> Kaiser Permanente Classic<br><input type="checkbox"/> Kaiser Permanente Value<br><input type="checkbox"/> Uniform Medical Plan | <b>Preferred Provider Organization</b><br><input type="checkbox"/> Uniform Dental Plan (Group #3000)<br>(may receive services from any provider)<br><b>Managed-Care Plans</b><br><input type="checkbox"/> DeltaCare, administered by Washington Dental Service (Group #3100)<br>Dentist name _____<br>(must receive services from <i>DeltaCare provider</i> )<br><input type="checkbox"/> Willamette Dental of Washington, Inc.<br>Clinic location _____<br>(must receive services from <i>Willamette Dental Group provider</i> )<br><b>Note:</b> Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare. |

| <b>Section 6: LIFE INSURANCE</b>   | <b>Section 7: LONG-TERM DISABILITY</b> |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
|--|--|----------------------------------|---|----------|--|-------|--|-------|---|-------|---------------------------------|-------|---------------------------------|-------|---|-------|--|-------|--|---------------------------------|----------------------------------|----------------------------------|---------------------------------|----------------------------------|----------------------------------|---------------------------------|----------------------------------|--|
| <table border="1"> <thead> <tr> <th>Current Enrollment with Agency</th> <th>Coverage Amount</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/> Basic Part A (\$5.23/month)</td> <td>\$25,000</td> </tr> <tr> <td><input type="checkbox"/> Part B – Dependent/Children</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part B – Spouse</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part B – Supplemental Spouse</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part C</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part D</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part E with Dependents</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part E without Dependents</td> <td>_____</td> </tr> </tbody> </table> <p><b>Desired Enrollment while Self-Paying</b><br/> <input type="checkbox"/> I wish to maintain the same coverage I had as an active employee. _____ (initials)<br/> <input type="checkbox"/> I do not wish to continue the life coverage while eligible for self-pay; I understand that I must reapply and submit evidence of insurability to reinstate optional life insurance when I return to work. _____ (initials)</p> | Current Enrollment with Agency         | Coverage Amount                  | <input checked="" type="checkbox"/> Basic Part A (\$5.23/month) | \$25,000 | <input type="checkbox"/> Part B – Dependent/Children | _____ | <input type="checkbox"/> Part B – Spouse | _____ | <input type="checkbox"/> Part B – Supplemental Spouse | _____ | <input type="checkbox"/> Part C | _____ | <input type="checkbox"/> Part D | _____ | <input type="checkbox"/> Part E with Dependents | _____ | <input type="checkbox"/> Part E without Dependents | _____ | <p>This section applies <b>ONLY</b> to employees on <b>educational leave</b>.</p> <p><b>Current Enrollment with Agency</b><br/> <input checked="" type="checkbox"/> Basic (\$2.25/month)</p> <table border="1"> <tr> <td><input type="checkbox"/> 30–Day</td> <td><input type="checkbox"/> 120–Day</td> <td><input type="checkbox"/> 300–Day</td> </tr> <tr> <td><input type="checkbox"/> 60–Day</td> <td><input type="checkbox"/> 180–Day</td> <td><input type="checkbox"/> 360–Day</td> </tr> <tr> <td><input type="checkbox"/> 90–Day</td> <td><input type="checkbox"/> 240–Day</td> <td></td> </tr> </table> <p><b>Desired Enrollment while Self-Paying</b><br/> <input type="checkbox"/> I wish to maintain the same coverage I had as an active employee. _____ (initials)<br/> <input type="checkbox"/> I do not wish to maintain the same coverage I had as an active employee. _____ (initials)</p> | <input type="checkbox"/> 30–Day | <input type="checkbox"/> 120–Day | <input type="checkbox"/> 300–Day | <input type="checkbox"/> 60–Day | <input type="checkbox"/> 180–Day | <input type="checkbox"/> 360–Day | <input type="checkbox"/> 90–Day | <input type="checkbox"/> 240–Day |  |
| Current Enrollment with Agency   | Coverage Amount                        |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input checked="" type="checkbox"/> Basic Part A (\$5.23/month)  | \$25,000                               |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part B – Dependent/Children   | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part B – Spouse   | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part B – Supplemental Spouse  | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part C  | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part D  | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part E with Dependents  | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> Part E without Dependents   | _____                                  |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> 30–Day  | <input type="checkbox"/> 120–Day       | <input type="checkbox"/> 300–Day |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> 60–Day  | <input type="checkbox"/> 180–Day       | <input type="checkbox"/> 360–Day |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |
| <input type="checkbox"/> 90–Day  | <input type="checkbox"/> 240–Day       |                                  |   |          |  |       |  |       |   |       |                                 |       |                                 |       |   |       |  |       |  |                                 |                                  |                                  |                                 |                                  |                                  |                                 |                                  |  |

**Section 8: SIGNATURE** Required

I have received and read the *Continuation of Coverage Election Notice* including any appendices. 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 rules, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, 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.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Benefits Services Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund.

This form replaces all previous forms and submissions I have made for PEBB benefits.

**HCA's Privacy Notice:** We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to [www.hca.wa.gov](http://www.hca.wa.gov).

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return to:** Washington State Health Care Authority  
 P.O. Box 42684  
 Olympia, WA 98504-2684

**If payment enclosed, return to:** Washington State Health Care Authority  
 P.O. Box 42695  
 Olympia, WA 98504-2695