



Public Employees Benefits Board (PEBB) 2008 COBRA Continuation or Extension of Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **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.

| | | |
|--|---|---|
| Employee/Retiree Information ONLY | Employee/retiree name | |
| | Employee/retiree social security number | Date employer coverage ended (mm/dd/yyyy) |

I/we elect COBRA continuation coverage as indicated below:

Section 1: SUBSCRIBER INFORMATION

| | | | | |
|---|--|--|----------------------|------------------|
| Social security number | Sex <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) () | Home phone number (including area 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 event _____ | | | | |
| Are you covered by another group medical or dental plan? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Effective date _____ | |
| Are you disabled under Title II (OASDI) of the Social Security Act? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Effective date _____ | |
| Are you disabled under Title XVI (SSI) of the Social Security Act? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Effective date _____ | |
| If yes, you must send a copy of your Social Security Disability Award letter. | | | | |
| Are you enrolled in Part(s) A and/or B of Medicare? | | Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No | Effective date _____ | |
| | | Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No | Effective date _____ | |
| Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form. | | | | |

Section 2: SPOUSE OR QUALIFIED DOMESTIC PARTNER INFORMATION

| | | |
|---|--|--|
| Social security number | Date of marriage or date partnership established/registered (mm/dd/yyyy) | Sex <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 event _____ | | |
| Are you covered by another group medical or dental plan? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you disabled under Title II (OASDI) of the Social Security Act? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you disabled under Title XVI (SSI) of the Social Security Act? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, you must send a copy of your Social Security Disability Award letter. | | |
| Are you enrolled in Part(s) A and/or B of Medicare? | | Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Effective date _____ | | |
| Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form. | | |

Visit our Web site at www.pebb.hca.wa.gov

Section 3: FAMILY MEMBER INFORMATION Use additional forms for more members. List only eligible family members.

| | | | | |
|---|----------------------------|------------------------|--|--|
| A | Relationship to subscriber | Social security number | <input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <i>Check only if age 20 or older.</i> | Sex <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 event _____ | | | | |
| Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| Are you disabled under Title II (OASDI) of the Social Security Act? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| Are you disabled under Title XVI (SSI) of the Social Security Act? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| If yes, you must send a copy of your Social Security Disability Award letter. | | | | |
| Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form. | | | | |

| | | | | |
|---|----------------------------|------------------------|--|--|
| B | Relationship to subscriber | Social security number | <input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <i>Check only if age 20 or older.</i> | Sex <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 event _____ | | | | |
| Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| Are you disabled under Title II (OASDI) of the Social Security Act? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| Are you disabled under Title XVI (SSI) of the Social Security Act? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| If yes, you must send a copy of your Social Security Disability Award letter. | | | | |
| Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____ | | | | |
| Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form. | | | | |

Section 4: MEDICAL PLAN SELECTION
Check only one. Contact plans for more information; their addresses are shown at the end of this form.

Aetna Public Employees Plan of Washington

Group Health Cooperative

Group Health Value

Group Health Classic

Kaiser Foundation Health Plan of the Northwest

Kaiser Permanente Classic

Kaiser Permanente Value

Medicare Supplement Plan E, administered by Premera Blue Cross

Medicare Supplement Plan J, administered by Premera Blue Cross

PacifiCare of Washington, Inc.

Secure Horizons Classic (Medicare enrollees only)

Secure Horizons Value (Medicare enrollees only)

Uniform Medical Plan

Section 5: DENTAL PLAN SELECTION
Check only one. Contact plans for more information; their addresses are shown at the end of this form.

Preferred Provider Organization

Uniform Dental Plan (Group #3000)
 (may receive services from any provider)

Managed Care Plans

DeltaCare, Administered by Washington Dental Service (Group #3100)
 Dentist name _____
 (must receive services from DeltaCare provider)

Willamette Dental of Washington, Inc.
 Clinic location _____
 (must receive services from Willamette Dental Group provider)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 6: 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.

Subscriber's signature _____ Date _____

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

PacifiCare of Washington, Inc., 7525 SE 24th Street, Suite 200, P.O. Box 9005, Mercer Island, WA 98040-9005

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327

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