

Public Employees Benefits Board (PEBB)

# 2008 Employee Enrollment/Change

- List all eligible family members and indicate their enrollment status on this form.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if required (students age 19 through 23, extended dependents, and dependents with disabilities).  
Forms are available on our website.

<b>Are you making changes to an existing account?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what type of changes:</b> <i>(Check all that apply.)</i> <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan <input type="checkbox"/> Adding family member <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Waiving coverage <input type="checkbox"/> Termination
Are you or any eligible family members enrolled in PEBB coverage under another account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Section 1: Subscriber Information</b>				
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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) (       )		
<b>Medical Coverage</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____	<i>If waiving, see Section 6.</i> <b>Note:</b> If you waive coverage, medical coverage will automatically be waived for all family members.		
<b>Dental Coverage</b>	<input checked="" type="checkbox"/> Enroll      (Dental may not be waived.)			

<b>Section 2: Spouse or Qualified Domestic Partner</b>				
<i>List your eligible spouse or qualified domestic partner and indicate their enrollment status, even if you do not want coverage for them; they <b>cannot</b> be enrolled in any other PEBB coverage.</i>				
<b>Relationship to Subscriber</b>				
If adding a spouse, please attach a completed <i>Spouse or Qualified Domestic Partner Certification</i> form. If adding a qualified domestic partner, please attach either a completed <i>Spouse or Qualified Domestic Partner Certification</i> form, or a copy of your <i>Certificate of State Registered Domestic Partnership</i> or registration card and a <i>Declaration of Tax Status</i> form.				
<input type="checkbox"/> Spouse: date of marriage _____ <input type="checkbox"/> Qualified domestic partner: date established/registered _____				
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (if different from subscriber)		City	State	ZIP Code
Date of birth (mm/dd/yyyy)				
<b>Medical Coverage</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____	<i>If waiving, see Section 6.</i>		
<b>Dental Coverage</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			
<b>Terminate Medical &amp; Dental Coverage</b>				
<input type="checkbox"/> Divorce/Termination of partnership: date of event _____ Please provide his/her new address _____ _____				
<input type="checkbox"/> Death: date of event _____ <input type="checkbox"/> Other: _____ Date effective _____				
<b>Visit our Web site at <a href="http://www.pebb.hca.wa.gov">www.pebb.hca.wa.gov</a></b>				



Agency name	Agency/subagency	Ins. effective date	Hire date
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**Section 3: Family Member Information** (such as child, etc.)

List all **eligible** family members and indicate their enrollment status; family members **cannot** be enrolled in any other PEBB coverage. **Use additional forms for more members.** Please attach appropriate **dependent certification** form if required (students age 20 through age 23, extended dependents, and dependents with disabilities).

<b>A</b>	Relationship to subscriber	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number	
Last name		First name		Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)				City	State	ZIP Code
<b>Medical Coverage</b>		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____		<input type="checkbox"/> Terminate		
<b>Dental Coverage</b>		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____		Reason _____		
		<i>If waiving, see Section 6.</i>		Date effective _____		
<b>B</b>	Relationship to subscriber	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number	
Last name		First name		Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)				City	State	ZIP Code
<b>Medical Coverage</b>		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____		<input type="checkbox"/> Terminate		
<b>Dental Coverage</b>		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____		Reason _____		
		<i>If waiving, see Section 6.</i>		Date effective _____		
<b>C</b>	Relationship to subscriber	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number	
Last name		First name		Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)				City	State	ZIP Code
<b>Medical Coverage</b>		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____		<input type="checkbox"/> Terminate		
<b>Dental Coverage</b>		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____		Reason _____		
		<i>If waiving, see Section 6.</i>		Date effective _____		

**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 Classic

Group Health Value

Kaiser Foundation Health Plan of the Northwest

Kaiser Permanente Classic

Kaiser Permanente Value

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 or clinic code \_\_\_\_\_  
(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*

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) or premiums paid on my behalf. 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, denial of PEBB benefits, and loss of my job.

The PEBB Benefits Services Program will verify eligibility for me and my family members.

If I or my family members choose to waive medical/dental, I understand I can re-enroll within 60 days of adding a new family member, losing other health coverage (with proof of continuous enrollment), or during the annual open enrollment period. If I waive medical for myself, I also waive medical for my family members.

I allow my employer to deduct money from my earnings to pay for the insurance coverage I requested.

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).

Subscriber's signature \_\_\_\_\_ Date \_\_\_\_\_

**Please sign and date this form. Return completed form to your personnel, payroll, or benefits office.**

**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

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