



Public Employees Benefits Board (PEBB)
**2009 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 (spouse or qualified domestic partner, students age 20 through age 23, extended dependents, and dependents with disabilities.)
- If you have a child age 20-24 who is not a student, he or she may qualify for PEBB adult dependent coverage. (See the *Adult Dependent Enrollment/Change* form.)

Forms are available at www.pebb.hca.wa.gov or by calling 1-800-200-1004.

Qualifying event <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 _____		

Section 1: SUBSCRIBER INFORMATION				Date employer coverage ended	
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) ()	
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 you want to terminate coverage _____					
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, attach a copy of your Medicare card(s) along with this form.					

Section 2: SPOUSE OR QUALIFIED DOMESTIC PARTNER INFORMATION					
<i>List only eligible family members and indicate their enrollment status.</i>					
Relationship to subscriber: 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
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 you want to terminate coverage _____					
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, attach 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 (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? <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: Medical/Dental Medical only Dental only
 Cancel all coverage Reason _____ Date you want to terminate coverage _____

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.

Section 4: CHANGES Check all that apply. You must submit this form and any dependent forms within 60 days of the event.

<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan <input type="checkbox"/> Adding a spouse or qualified domestic partner due to marriage or qualified domestic partnership (see Section 2) <input type="checkbox"/> Adding newly acquired child(ren) due to birth, adoption, guardianship, marriage, or qualified domestic partnership <input type="checkbox"/> Adding a dependent due to court order or medical support order (attach copy of court order or medical support order) <input type="checkbox"/> Loss of other comprehensive group coverage <input type="checkbox"/> Change in employment status	<input type="checkbox"/> Terminating a dependent's coverage due to divorce, legal separation, or termination of qualified domestic partnership Provide former spouse's or partner's new address _____ <input type="checkbox"/> Terminating a dependent's coverage due to death <input type="checkbox"/> Terminating a dependent's coverage due to loss of eligibility for PEBB coverage <input type="checkbox"/> Other (explain) _____ Date of event _____
---	--

<p>Section 5: MEDICAL PLAN SELECTION Check only one.</p> <p>Contact plans for more information; their contact information is shown at the end of this form.</p> <input type="checkbox"/> Aetna Public Employees Plan of Washington Group Health Cooperative <input type="checkbox"/> Group Health Classic <input type="checkbox"/> Group Health Value Kaiser Foundation Health Plan of the Northwest <input type="checkbox"/> Kaiser Permanente Classic <input type="checkbox"/> Kaiser Permanente Value <input type="checkbox"/> Uniform Medical Plan	<p>Section 6: DENTAL PLAN SELECTION Check only one.</p> <p>Preferred Provider Organization <input type="checkbox"/> Uniform Dental Plan (Group #3000) (may receive services from any provider) Managed-Care Plans <input type="checkbox"/> DeltaCare, administered by Washington Dental Service (Group #3100) Dentist name _____ (must receive services from DeltaCare provider) <input type="checkbox"/> 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. </p>
--	---

Section 7: LIFE INSURANCE

Current Enrollment with Agency	Coverage Amount
<input checked="" type="checkbox"/> Basic Part A (\$5.07/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	_____

Desired Enrollment while Self-Paying

I wish to maintain the same coverage I had as an active employee. _____ (initials)

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)

Section 8: LONG-TERM DISABILITY

This section applies ONLY to employees on educational leave.

Current Enrollment with Agency

Basic (\$2.00/month)

<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	

Desired Enrollment while Self-Paying

I wish to maintain the same coverage I had as an active employee. _____ (initials)

I do not wish to maintain the same coverage I had as an active employee. _____ (initials)

Section 9: 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 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 *Leave Without Pay Continuation Coverage Election* forms I have submitted 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.

Signature _____ Date _____

Return to:

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

If payment is enclosed, return to:

Washington State Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

2009 PEBB MEDICAL CONTRACTORS

Aetna Public Employees Plan of Washington, P.O. Box 14089, Lexington, KY 40512-4089
1-800-222-9205 or TTY 1-800-628-3323

Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850
1-800-762-6004 or TTY 1-888-923-5622

2009 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611
1-800-360-1909