

Public Employees Benefits Board (PEBB)

2009 Employee Enrollment/Change

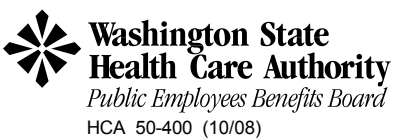
- List all eligible family members and indicate their enrollment status on this form.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate dependent certification form(s) if required (students age 20 through 23, extended dependents, or 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. The *Adult Dependent Enrollment/Change* form is available online.

Forms are available on our Web site at www.pebb.hca.wa.gov.

Are you making changes to an existing account? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what 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 _____
Are you or any eligible family members enrolled in PEBB coverage under another account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 1: Subscriber Information					
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) ()		
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ Dental Coverage <input checked="" type="checkbox"/> Enroll (Dental may not be waived.)			If waiving, see Section 6. Note: If you waive coverage, medical coverage will automatically be waived for all family members except for adult dependents (see WAC 182-12-260[4][d]).		

Section 2: Spouse or Qualified Domestic Partner <i>List your eligible spouse or qualified domestic partner and indicate their enrollment status, even if you do not want coverage for them; they cannot be enrolled in any other PEBB coverage.</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	
Address (if different from subscriber)			City	State	ZIP Code
Date of birth (mm/dd/yyyy)					
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			<input type="checkbox"/> Terminate: date effective _____		
Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ If waiving, see Section 6.			Reason _____		



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).					
A	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
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			<input type="checkbox"/> Terminate: date effective _____		
Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			Reason _____		
<i>If waiving, see Section 6.</i>					
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
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			<input type="checkbox"/> Terminate: date effective _____		
Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			Reason _____		
<i>If waiving, see Section 6.</i>					
C	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
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			<input type="checkbox"/> Terminate: date effective _____		
Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			Reason _____		
<i>If waiving, see Section 6.</i>					

Section 4: Medical Plan Selection *Check only one.*

Contact plans for more information; their contact information is 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 contact information is 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 Program will verify eligibility for me and my family members.

If I or my family members choose to waive medical/dental, I understand I/we can re-enroll during the annual open enrollment period or within 60 days of a special open enrollment event as defined in WAC 182-12-262. If I waive medical for myself, I also waive medical for my family members (except adult dependents).

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.

Subscriber's signature _____ Date _____

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

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