



2009 PEBB-Sponsored Retiree Coverage Election Form (Open Enrollment)

- List all eligible family members and indicate their enrollment status on this form.
- If deferring PEBB retiree coverage, complete sections 1 and 7.
- 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 age 23, extended dependents, and dependents with disabilities). Forms are available at www.pebb.hca.wa.gov.
- 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 at www.pebb.hca.wa.gov or by calling 1-800-200-1004.
- If re-enrolling after deferment, you must attach proof of continuous medical coverage since your date of deferment.
- If you are a surviving spouse, qualified domestic partner, or dependent, provide the social security number (SSN) of the deceased retiree or employee in the "Retiree or employee information ONLY" section below. Provide **your** SSN in Section 1 Subscriber Information.

Retiree or employee information ONLY	Retiree or employee name	Retiree or employee social security number
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Additions or Changes <i>Check all that apply.</i>	Retiree changed: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Medical plan <input type="checkbox"/> Dental plan Change in family status: <input type="checkbox"/> Adding a spouse or qualified domestic partner *(see note below) <input type="checkbox"/> Adding family member 1 (from Section 3) <input type="checkbox"/> Adding family member 2 (from Section 3)
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*If adding a spouse, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.
 *If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Domestic Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form.

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) ()	

Election *Check the boxes that apply to you.*

Medical Coverage Enroll: Medical only Medical and dental

Re-enrollment after deferment (You must provide proof of continuous coverage.) **Date other coverage ended** _____

Defer (due to enrollment in your or your spouse's or qualified domestic partner's employer coverage)

Defer (due to enrollment in a federal retiree program, for example, TRICARE)
If deferring, see Section 8. Note: This defers coverage for all family members.

Defer (due to enrollment in Medicare and Medicaid with creditable coverage)

Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB program.

Date you want to defer or terminate coverage _____

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) Yes No If yes, effective date _____

Part B (medical) Yes No If yes, effective date _____

If yes, attach a copy of your Medicare card to this election form.

Are you enrolled in Part D (prescription drug coverage) of Medicare? Yes No If yes, effective date _____

Are you enrolled in Medicaid with prescription coverage? Yes No

Are you receiving Social Security disability? Yes No If yes, effective date _____

If yes, attach a copy of your Social Security Disability Award letter.

Section 2: Spouse or Qualified Domestic Partner*List only family members you wish to cover; family members cannot be enrolled in two PEBB medical or dental accounts at the same time.***Relationship to subscriber**If adding a spouse, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form. **Spouse:** date of marriage _____ **Qualified domestic partner:** date established/registered _____

Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Address (if different from subscriber)	City	State	ZIP Code
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Date of birth (mm/dd/yyyy)	
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Are you waiving coverage for your spouse or qualified domestic partner? Yes NoAre you enrolled in Part(s) A and/or B of Medicare? **Part A (hospital)** Yes No If yes, effective date _____**Part B (medical)** Yes No If yes, effective date _____**If yes, attach a copy of your Medicare card to this election form.**Are you enrolled in Part D (prescription drug coverage) of Medicare? Yes No If yes, effective date _____Are you enrolled in Medicaid with prescription coverage? Yes NoAre you receiving Social Security disability? Yes No If yes, effective date _____**If yes, attach a copy of your Social Security Disability Award letter.****Section 3: Family Member Information** (such as a child) *Use additional forms for more members.*

1	Relationship	Last name	First name	Middle initial
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Social security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <i>Check only if age 20 or older.</i>
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Address (if different from subscriber)	City	State	ZIP Code
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Are you waiving coverage for this dependent? Yes NoAre you enrolled in Part(s) A and/or B of Medicare? **Part A (hospital)** Yes No If yes, effective date _____**Part B (medical)** Yes No If yes, effective date _____**If yes, attach a copy of your Medicare card to this election form.**Are you enrolled in Part D (prescription drug coverage) of Medicare? Yes No If yes, effective date _____Are you enrolled in Medicaid with prescription coverage? Yes NoAre you receiving Social Security disability? Yes No If yes, effective date _____**If yes, attach a copy of your Social Security Disability Award letter.***(continued on next page)*

Section 3: Family Member Information (continued) *Use additional forms for more members.*

2	Relationship	Last name	First name	Middle initial
Social security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <i>Check only if age 20 or older.</i>	
Address (if different from subscriber)		City	State	ZIP Code
Are you waiving coverage for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you enrolled in Part(s) A and/or B of Medicare?				
Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____ Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				
If yes, attach a copy of your Medicare card to this election form.				
Are you enrolled in Part D (prescription drug coverage) of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____ Are you enrolled in Medicaid with prescription coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you receiving Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				
If yes, attach a copy of your Social Security Disability Award letter.				

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

Contact the plans for more information; their contact information is at the end of this form.

<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"/> Medicare Supplement Plan E, administered by Premera Blue Cross* <input type="checkbox"/> Medicare Supplement Plan J, administered by Premera Blue Cross* PacifiCare of Washington, Inc. <input type="checkbox"/> Secure Horizons Classic ‡ (Medicare enrollees only) <input type="checkbox"/> Secure Horizons Value ‡ (Medicare enrollees only) <input type="checkbox"/> Uniform Medical Plan
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‡ These plans offer Medicare Advantage plans available only to Medicare enrollees where available. Complete and attach the Medicare Advantage Plan Election Form (form C).
 * Complete and return Form B to enroll in a Medicare Supplement Plan.

Section 5: Dental Plan Selection *Check only one. You must enroll in medical coverage to enroll in dental.*

If you select dental coverage for yourself, you must keep dental coverage for at least 2 calendar years. However, you may change dental plans within those two years.
 Contact the plans for more information; their contact information is at the end of this form.

Preferred Provider Organization <input type="checkbox"/> Uniform Dental Plan (Group #3000) (may receive services from any provider) <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare. </div>	Managed Care Plans <input type="checkbox"/> DeltaCare, administered by Washington Dental Service (Group #3100) Dentist name or clinic code _____ (must receive services from DeltaCare provider) <input type="checkbox"/> Willamette Dental of Washington, Inc. Clinic location _____ (must receive services from Willamette Dental Group Provider)
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Cancel Dental
 I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB dental plan for at least two years or if I am now covered under employer-sponsored dental. If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

Section 6: Authorization for Premium Payment

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage.

Yes, deduct from my pension. No, I will send my payment monthly.

If enrolling after deferring coverage, you must send your first monthly payment before we can enroll you. Please enclose your check payable to Washington State Treasurer.

Section 7: 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, and denial of PEBB benefits.

I understand that if I enroll in dental, I must remain enrolled for at least two calendar years.

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

I can defer enrollment in a PEBB health plan for:

- Comprehensive, employer-sponsored coverage
- Creditable Medicare/Medicaid coverage
- Federal retiree coverage (may only re-enroll in PEBB health plan[s] one time)

If I die, my eligible surviving family members must complete an enrollment form to enroll in or defer PEBB retiree insurance coverage within 60 days of my death.

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.

Retiree signature _____ Date _____

Return form to:

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684
or fax to: 360-923-2608

Be sure to sign and date this form.



**Washington State
Health Care Authority**
Public Employees Benefits Board

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

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 N.E. Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

PacifiCare of Washington, Inc., 7525 SE 24th Street, Suite 200, P.O. Box 9005, Mercer Island, WA 98040-9005
Secure Horizons: 1-800-647-7328 or TTY 1-800-387-1074

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98125-1850
1-800-304-5103 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

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