



Public Employees Benefits Board (PEBB)

2009 PEBB-Sponsored Retiree Coverage Election Form

- List all eligible family members and indicate their enrollment status on this form.
- If deferring PEBB retiree coverage, complete sections 1 and 9.
- **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 of the deceased retiree or employee in the retiree/employee section below. Provide **your** SSN in the Section 1 Subscriber Information area.

Check One	<input type="checkbox"/> I am a new retiree	<input type="checkbox"/> I am changing an existing account.
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Retiree or employee information ONLY	Retiree or employee name		Retirement system
	Retiree or employee social security number		Retirement date (mm/dd/yyyy)
For K-12 school district retirees only	School district	When does your current school district medical/dental coverage end? (mm/dd/yyyy)	
Re-enrollment after deferment	Date other coverage ended (mm/dd/yyyy)		

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 <i>Check the boxes that apply to you.</i>					
Medical Coverage					
<input type="checkbox"/> Enroll: <input type="checkbox"/> Medical only <input type="checkbox"/> Medical and dental					
<input type="checkbox"/> Re-enrollment after deferment (You must provide proof of continuous coverage.) Date other coverage ended _____					
<input type="checkbox"/> Defer (due to enrollment in your or your spouse's or qualified domestic partner's employer coverage)					
<input type="checkbox"/> Defer (due to enrollment in a federal retiree program, for example, TRICARE)					
If deferring, see Section 9. Note: This defers coverage for all family members.					
<input type="checkbox"/> Defer (due to enrollment in Medicare and Medicaid with creditable coverage)					
<input type="checkbox"/> 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? If yes, attach a copy of your Medicare card to this election form.		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 _____			
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? If yes, attach a copy of your Social Security Disability Award letter.		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____			

Section 2: Spouse or Qualified Domestic Partner*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 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. **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 _____

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

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

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

Part B (medical) Yes No If yes, effective date _____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 (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 _____ If yes, attach a copy of your Medicare card to this election form. Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____				
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: 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 _____
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Section 5: Medical Plan Selection Check only one.

Contact 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 6: 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 years. However, you may change dental plans within those two years.

Contact 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="background-color: #e0e0e0; 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 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB employee life insurance. You must apply for Retiree Term Life Insurance at the time of retirement. The cost is \$2.19 per month regardless of age.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. **Yes** **No**

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Coverage
Under 65	\$3,000
65 through 69	\$2,100
70 and over	\$1,800

Beneficiary _____ Beneficiary's SSN _____

Relationship to retiree _____ Beneficiary's date of birth _____

Beneficiary's address _____

Section 8: 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 (**Note:** You must make the first payment before you will be enrolled. Make checks payable to the Washington State Treasurer and send with this form to Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695.)

Section 9: 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.

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.

I understand that if I enroll in dental, I must remain enrolled for at least two 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 _____



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

Return form to:

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

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

Be sure to sign and date this form.

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**

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