

Public Employees Benefits Board (PEBB)
2010 Adult Dependent Enrollment/Change



- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before we can enroll you.** (Make checks payable to Washington State Treasurer.)

Are you making changes to an existing adult dependent account? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what types of changes? (Check all that apply.) <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Phone number(s) <input type="checkbox"/> Plan(s) <input type="checkbox"/> Termination Effective date _____
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Employee/Retiree Information ONLY	Employee/retiree name	Employee/retiree social security number
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Section 1: ADULT DEPENDENT INFORMATION					
Social security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	Middle initial	
Street address			Apt./unit number		
City	State	ZIP Code	County of residence		
Mailing address (if different from above)			City	State	ZIP Code
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ()		Home phone number (including area code) ()		
Are you married? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, are you legally separated? <input type="checkbox"/> No <input type="checkbox"/> Yes (provide copy of court documents)			
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only (not available to dependents of retirees)					

Section 2: MEDICAL PLAN SELECTION <i>Check only one.</i>	
You must enroll in the same plan as the employee/retiree unless you live outside of that plan's service area. Contact the plans for benefits information; their contact information is shown 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	<input type="checkbox"/> 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

Section 3: DENTAL PLAN SELECTION <i>Check only one.</i>	
You must enroll in the same plan as the employee/retiree unless you live outside of that plan's service area. Contact the plans for benefits information; their contact information is shown at the end of this form.	
Preferred Provider Organization <input type="checkbox"/> Uniform Dental Plan, administered by Washington Dental Service/Delta Dental of Washington (Group #3000) (may receive services from <i>any provider</i>)	Managed Care Plans <input type="checkbox"/> DeltaCare, administered by Washington Dental Service (Group #3100) Dentist name or clinic code _____ (must receive services from a <i>DeltaCare provider</i>) <input type="checkbox"/> Willamette Dental of Washington, Inc. Clinic location _____ (must receive services from a <i>Willamette Dental Group provider</i>)

Section 4: SUBSCRIBER (EMPLOYEE/RETIREE) AUTHORIZATION FOR ENROLLMENT AND PREMIUM PAYMENT	
By signing this form, I declare that the information I have provided to enroll my adult dependent 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) and my adult dependent may also lose PEBB benefits as of the last day of the month he or she qualified.	
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.	
If I send payment, this does not mean that my adult dependent will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for my adult dependent. If he or she does not qualify, I will receive a refund.	
I understand, as the subscriber requesting enrollment in PEBB coverage for the adult dependent, that I am responsible for paying the total monthly premium cost of this coverage. This premium may not be payroll deducted. This form replaces all previous <i>Adult Dependent Enrollment/Change</i> forms I have submitted for PEBB benefits for the person listed in Section 1 of this form.	
Subscriber's (employee/retiree) signature _____	Date _____

Section 5: ADULT DEPENDENT AUTHORIZATION FOR USE OR DISCLOSURE *Optional*

I authorize the use or disclosure of personal health information about me as described in Section 6. I understand that this authorization is voluntary and I may cancel it at any time as described in Section 6. I understand that the same strict confidentiality standards that apply to my medical records under the Health Insurance Portability and Accountability Act (HIPAA) also apply to my health coverage records, and will not be shared with my employer or any other participants.

I authorize the Health Care Authority to provide information about me to _____ (print name of parent or guardian) for the purpose of eligibility, enrollment, and billing issues.

Adult dependent's signature (optional) _____ Date _____

Section 6: ADULT DEPENDENT—IMPORTANT INFORMATION ABOUT YOUR RIGHTS *Required*

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time by notifying the Health Care Authority (HCA) in writing. The cancellation will not affect any information either received or given by the Health Care Authority before they received the cancellation notice. This authorization will automatically expire at the end of my participation in the PEBB Program.
- I may see a copy of this form if I ask for it.
- The person I authorize to receive information about me might share it with another person or organization. I have the right to ask the Health Care Authority to ensure that its employees do not share information about me with anyone other than the person noted above without my further authorization. Exceptions may include people or organizations needed to determine my eligibility and enrollment, or as allowed by law.

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.

Adult dependent's signature (required) _____ Date _____

Please sign and date this form.

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

If payment enclosed, return to: Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695
Make checks payable to Washington State Treasurer.

2010 Monthly Premiums for Adult Dependents

Medical Plans	Aetna Public Employees Plan	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Uniform Medical Plan
Subscriber only	\$531.44	\$470.73	\$421.44	\$471.51	\$441.08	\$440.20

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Uniform Dental Plan	Willamette Dental
Subscriber only	\$37.19	\$44.53	\$40.18

Dental Plans Dental Only	DeltaCare, administered by Washington Dental Service	Uniform Dental Plan	Willamette Dental
Subscriber only	\$43.63	\$50.97	\$46.62

2010 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 91118, Seattle, WA 98111-9218
 1-800-762-6004 or TTY 1-888-923-5622

2010 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Ave. NE, Seattle, WA 98115-2157 | 1-800-650-1583
Uniform Dental Plan, 9706 Fourth Ave. 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