

Public Employees Benefits Board (PEBB)

2010 COBRA Continuation or Extension of Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- List eligible family members you wish to cover or disenroll.
- Attach appropriate dependent certification form(s) for students age 20 through 23, extended dependents, and dependents with disabilities.
- If you have an unmarried child age 20 through 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 at www.pebb.hca.wa.gov or by calling 1-800-200-1004.

Employee or Retiree Information ONLY	Employee/retiree name	
	Employee/retiree social security number	Date employer coverage ended (mm/dd/yyyy)
Are you making changes to an existing account? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section 1: Subscriber Information					
<i>If you are requesting coverage as the dependent of someone whose coverage has ended, fill in your information here and the employee/retiree's information above.</i>					
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)	Daytime phone number (including area code) ()		Evening phone number (including area 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 of event _____					
Are you covered by another group medical plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____		
Are you covered by another group dental plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____		
Are you disabled under Title II (OASDI) of the Social Security Act?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____		
Are you disabled under Title XVI (SSI) of the Social Security Act?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____		
If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.					
Are you enrolled in Part(s) A and/or B of Medicare?		Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____		
		Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____		
If you are enrolled in Medicare Part(s) A and/or B, attach a copy of your Medicare card to this form.					

Visit our website at www.pebb.hca.wa.gov

Section 2: Spouse or Washington State-Registered Domestic Partner Information

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.

Relationship to subscriber:

If adding a registered domestic partner, please attach a *Declaration of Tax Status* form.

Spouse: date of marriage _____ Domestic partner: date qualified/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)
Street address (if different from subscriber)		City		State	ZIP Code

Select coverage to continue: Medical/Dental Medical only Dental only
 Cancel all coverage Reason _____ Date of event _____

Covered by another group medical plan? Yes No Effective date _____

Covered by another group dental plan? Yes No Effective date _____

Disabled under Title II (OASDI) of the Social Security Act? Yes No Effective date _____

Disabled under Title XVI (SSI) of the Social Security Act? Yes No Effective date _____

If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? Part A (hospital) Yes No Effective date _____

Part B (medical) Yes No Effective date _____

If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card to this form.

Section 3: Family Member Information (Such as child, etc.) List eligible family members you wish to cover or disenroll.

Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. Use additional forms for more members.

A	Relationship to subscriber	Social security number	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? Check only if age 20 or older.		Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)	
Street address (if different from subscriber)		City		State	ZIP Code

Select coverage to continue: Medical/Dental Medical only Dental only
 Cancel all coverage Reason _____ Date of event _____

Covered by another group medical plan? Yes No Effective date _____

Covered by another group dental plan? Yes No Effective date _____

Disabled under Title II (OASDI) of the Social Security Act? Yes No Effective date _____

Disabled under Title XVI (SSI) of the Social Security Act? Yes No Effective date _____

If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? Part A (hospital) Yes No Effective date _____

Part B (medical) Yes No Effective date _____

If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card to this form.

Section 4: Changes Check all that apply and give date of event. You must submit this form and any dependent forms no later than 60 days of the event.

- | | |
|--|--|
| <input type="checkbox"/> Name | <input type="checkbox"/> Loss of other comprehensive group coverage |
| <input type="checkbox"/> Address | <input type="checkbox"/> Change in employment status |
| <input type="checkbox"/> Medical plan | <input type="checkbox"/> Terminating a dependent's coverage due to divorce, legal separation, or termination of a domestic partnership
Provide former spouse's or partner's new address
_____ |
| <input type="checkbox"/> Dental plan | |
| <input type="checkbox"/> Adding a spouse due to marriage or a Washington State-registered domestic partner | |
| <input type="checkbox"/> Adding newly acquired child(ren) due to birth or adoption
(Submit this form as soon as possible to ensure claims payment. If adding the child increases the premium, you must submit this form within 12 months of birth or adoption.) | <input type="checkbox"/> Terminating a dependent's coverage due to death |
| <input type="checkbox"/> Adding newly acquired child(ren) due to guardianship, marriage, or Washington State-registered domestic partnership | <input type="checkbox"/> Terminating a dependent's coverage due to loss of eligibility for PEBB coverage |
| <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"/> Other (explain) _____ |
| | Date of event _____ |

(continued on next page)

Section 5: Medical Plan Selection

Check only one. Contact plans for benefits 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 ‡
- Medicare Supplement Plan E, administered by Premera Blue Cross*
 Medicare Supplement Plan J, administered by Premera Blue Cross*
- PacifiCare of Washington, Inc.
- SecureHorizons Classic (Medicare enrollees only) ‡
 SecureHorizons Value (Medicare enrollees only) ‡
- Uniform Medical Plan

‡ **These plans offer Medicare Advantage plans to Medicare enrollees where available. Complete and attach the *Medicare Advantage Plan Election Form (form C)* to enroll.**

* **Complete and return form B to enroll in a Medicare Supplement Plan.**

Section 6: 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, administered by Washington Dental Service/Delta Dental of Washington (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 a *DeltaCare provider*)
- Willamette Dental of Washington, Inc.
Clinic location _____
(must receive services from a *Willamette Dental Group provider*)

Section 7: 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 adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office.

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 *COBRA Continuation or Extension of Coverage* 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.

Subscriber's signature _____ Date _____

Please sign and date this form.**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

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

PacifiCare of Washington, Inc. (SecureHorizons), 9701 Data Park Drive, Minnetonka, MN 55343 **1-866-572-9396** or TTY **711**

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 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 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**