

Public Employees Benefits Board (PEBB)

2010 Employee Enrollment/Change

- List eligible family members you wish to cover or disenroll.
 - Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
 - If adding a new family member, attach appropriate **dependent certification** form(s) if enrolling a student age 20 through 23, extended dependent, or dependent with disabilities.
 - If you have a 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 on our website at www.pebb.hca.wa.gov.

Are you making changes to an existing account? Yes No

If yes, what changes? (Check all that apply and give date of event. You must submit this form and any dependent forms no later than **60 days** after 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 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"/> Adding newly acquired child(ren) due to guardianship, marriage, or Washington State-registered 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 a 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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Are you or any eligible family members enrolled in PEBB coverage under another account? Yes No

Section 1: Subscriber Information					
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
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) ()			
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____			<i>If waiving, see Section 6.</i> Note: If you waive coverage, you cannot enroll your eligible dependents in medical (except for adult dependents).		
Dental Coverage <input checked="" type="checkbox"/> Enroll (Dental may not be waived.)					

(continued on next page)

Agency name	Agency/subagency	Ins. effective date	Hire date
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Section 2: Spouse or Qualified Washington State-Registered Domestic Partner

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 completed *Declaration of Tax Status* form.

Spouse: date of marriage _____ Domestic partner: date qualified or registered _____

Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street address (if different from subscriber)	City	State	ZIP Code
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Date of birth (mm/dd/yyyy)	
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Medical Coverage Enroll Disenroll from medical: effective date _____
Reason _____

Dental Coverage Enroll Disenroll from dental: effective date _____
Reason _____

Section 3: Family Member Information (such as child)

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.** If adding a new family member, attach appropriate **dependent certification** form(s) if enrolling a student age 20 through 23, extended dependent, or dependent with disabilities).

A Relationship to subscriber	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? (Check only if age 20 or older.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number
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Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
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Address (if different from subscriber)	City	State	ZIP Code
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Medical Coverage Enroll Disenroll from medical: effective date _____
Reason _____

Dental Coverage Enroll Disenroll from dental: effective date _____
Reason _____

B Relationship to subscriber	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? (Check only if age 20 or older.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number
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Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
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Address (if different from subscriber)	City	State	ZIP Code
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Medical Coverage Enroll Disenroll from medical: effective date _____
Reason _____

Dental Coverage Enroll Disenroll from dental: effective date _____
Reason _____

C Relationship to subscriber	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? (Check only if age 20 or older.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number
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Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
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Address (if different from subscriber)	City	State	ZIP Code
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Medical Coverage Enroll Disenroll from medical: effective date _____
Reason _____

Dental Coverage Enroll Disenroll from dental: effective date _____
Reason _____

Section 4: 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

Uniform Medical Plan

Section 5: Dental Plan Selection*Check only one.*

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

Preferred Provider Organization

Uniform Dental Plan (Group #3000)
Administered by Washington Dental Service/Delta Dental of Washington
(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 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.

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.

The PEBB Program will verify eligibility for me and my family members.

If I waive medical/dental, I understand I can re-enroll during the annual open enrollment period or within 60 days of a special open enrollment event as defined in PEBB rules. If I waive medical for myself, I cannot enroll my eligible family members in medical (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.***

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 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

