



2010 PEBB-Sponsored Retiree Coverage Election Form

- List eligible family members you wish to cover or disenroll.
- 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.
- 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. Forms are available at www.pebb.hca.wa.gov.
- 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 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/Washington State-registered 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."

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	
Street address	Apt./Unit number	City	State	ZIP Code	
Mailing address (if different from above)		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/Washington State-registered domestic partner's employer coverage)
Deferral date _____

Defer (due to enrollment in a federal retiree program, for example, TRICARE) **Deferral date** _____

If deferring, see Section 9. Note: This defers coverage for all family members.

Defer (due to enrollment in Medicare and Medicaid with creditable coverage) **Deferral date** _____

Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB Program. **Termination date** _____

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) Yes No If yes, effective date _____

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 No If yes, effective date _____

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

Section 2: Spouse or Qualified/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 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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PEBB coverage for dependent Enroll Terminate Effective date _____ Reason _____

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 the Medicare card to this election form. **Part B (medical)** Yes No If yes, effective date _____

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

Enrolled in Medicaid with prescription coverage? Yes No If yes, effective date _____

Receiving Social Security Disability? Yes No If yes, effective date _____

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

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. 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.

1 Relationship to subscriber	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? Check only if age 20 or older.
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Street address (if different from subscriber)	City	State	ZIP Code
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PEBB coverage for dependent Enroll Terminate Effective date _____ Reason _____

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 the Medicare card to this election form. **Part B (medical)** Yes No If yes, effective date _____

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

Enrolled in Medicaid with prescription coverage? Yes No If yes, effective date _____

Receiving Social Security Disability? Yes No If yes, effective date _____

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

2	Relationship to subscriber	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>
Street address (if different from subscriber)			City	State ZIP Code
PEBB coverage for dependent <input type="checkbox"/> Enroll <input type="checkbox"/> Terminate Effective date _____ Reason _____				
Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of the 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 _____		
Enrolled in Part D (prescription drug coverage) of Medicare?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____		
Enrolled in Medicaid with prescription coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____		
Receiving Social Security disability?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____		

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"/> 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 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 benefits 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"/> SecureHorizons Classic ‡ (Medicare enrollees only) <input type="checkbox"/> SecureHorizons Value ‡ (Medicare enrollees only) <input type="checkbox"/> Uniform Medical Plan
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‡ 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. 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 two years. However, you may change dental plans within those two years. Contact plans for benefits information; their contact information is 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 any provider)	Managed Care Plans <input type="checkbox"/> DeltaCare, administered by Washington Dental Service (Group #3100) Dentist name or clinic code _____ (must receive services from a DeltaCare provider) <input type="checkbox"/> Willamette Dental of Washington, Inc. Clinic location _____ (must receive services from a 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.

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

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

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 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.

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 cannot enroll my eligible family members (except adult dependents).

I can defer enrollment in a PEBB health plan for:

- Comprehensive, employer-sponsored medical coverage that is not retiree coverage.
- Creditable Medicare/Medicaid coverage. (You may enroll your eligible family members in PEBB coverage in this case.)
- 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.

If you are a retiree of the Department of Retirement Systems (DRS), the PEBB Program may share your information with the DRS to better serve you.

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 _____



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

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

Be sure to sign and date this form.

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**