

2010 Employee Enrollment/Change for Medical Only Groups

- 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"/> 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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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		<i>If waiving, see Section 5.</i>		
<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: effective date _____		Note: If you waive coverage, you cannot enroll your eligible dependents in medical (except for adult dependents).		

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
Street address (if different from subscriber)			City	State
Date of birth (mm/dd/yyyy)				
Medical Coverage				
<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll: effective date _____ Reason _____				



Agency name	Agency/subagency	Ins. effective date	Hire date

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 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
	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State	ZIP Code

Medical Coverage Enroll Disenroll: 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
	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State	ZIP Code

Medical Coverage Enroll Disenroll: 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.

- | | |
|--|---|
| <input type="checkbox"/> Aetna Public Employees Plan of Washington | <input type="checkbox"/> Kaiser Foundation Health Plan of the Northwest |
| <input type="checkbox"/> Group Health Cooperative | <input type="checkbox"/> Kaiser Permanente Classic |
| <input type="checkbox"/> Group Health Classic | <input type="checkbox"/> Kaiser Permanente Value |
| <input type="checkbox"/> Group Health Value | <input type="checkbox"/> Uniform Medical Plan |

Section 5: 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 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, 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