



# 2008 PEBB-Sponsored Retiree Coverage Election Form

- List all eligible family members and indicate their enrollment status on this form.
- 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.
- Attach appropriate dependent certification form(s) if required (students age 20 through age 23, extended dependents, and dependents with disabilities). Forms are available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).
- If re-enrolling after deferment, you must attach proof of continuous medical coverage since your date of deferment and make the first payment before you will be enrolled. Make checks payable to the Washington State Treasurer.
- If you are a surviving spouse, qualified domestic partner, or dependent, provide the social security number of the deceased retiree or employee in the retiree/employee section below. Provide your SSN in the Section 1 SSN area.

|   |  |  |  |
|---|--|--|--|
| <b>Retiree or employee information ONLY</b>   | Retiree or employee name                   |  | Retirement system  |
|   | Retiree or employee social security number |  | Retirement date (mm/dd/yyyy)   |
| <b>For K-12 school district retirees only</b> | School district                            |  | When does your current <b>school district</b> medical/dental <b>coverage end?</b> (mm/dd/yyyy) |
|   | Date other coverage ended (mm/dd/yyyy)     |  |  |

| Section 1: Subscriber Information |                            |  |  |  |          |
|-----------------------------------|----------------------------|--|--|--|----------|
| Social security number            | Last name                  | First name                                     | Middle initial                                 | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |          |
| Address                           |                            | Apt./Unit number                               | City   | State  | ZIP Code |
| County of residence               | Date of birth (mm/dd/yyyy) | Work phone number (including area code)<br>( ) | Home phone number (including area code)<br>( ) |  |          |

| Election  |  |
|---|--|
| <b>Medical Coverage</b>   | <input type="checkbox"/> Enroll: <input type="checkbox"/> Medical only <input type="checkbox"/> Medical and dental<br><input type="checkbox"/> Re-enrollment after deferment (You must provide proof of continuous coverage.) Date other coverage ended _____<br><input type="checkbox"/> Defer (due to enrollment in your or your spouse's or qualified domestic partner's employer coverage)<br><div style="background-color: #e0e0e0; padding: 2px; text-align: center;"><b>If deferring, see Section 9. Note: This defers coverage for all family members.</b></div> <input type="checkbox"/> Defer (due to enrollment in a federal retiree program)<br><input type="checkbox"/> Defer (due to enrollment in Medicare and Medicaid with creditable coverage)<br><input type="checkbox"/> Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB program.<br>Date you want coverage to end _____ |
| Are you enrolled in Part(s) A and/or B of Medicare?<br>If yes, attach a copy of your Medicare card to this election form. | <b>Part A (hospital)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____<br><b>Part B (medical)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____  |
| Are you enrolled in Part D of Medicare?   | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____  |
| Are you enrolled in Medicaid with creditable coverage?  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Are you receiving Medicare disability?<br>If yes, attach a copy of your Social Security Disability Award letter.          | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date _____  |

(continued on next page)

**Section 2: Spouse or Qualified Domestic Partner**  
*Family members cannot be enrolled in any other PEBB coverage.*

**Relationship to subscriber**  
 If adding a spouse, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.  
 If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Domestic Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form.

**Spouse:** date of marriage \_\_\_\_\_  **Qualified domestic partner:** date established/registered \_\_\_\_\_

|  |           |            |                |  |
|--|-----------|------------|----------------|--|
| Social security number                 | Last name | First name | Middle initial | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Address (if different from subscriber) |           | City       | State          | ZIP Code   |
| Date of birth (mm/dd/yyyy)             |           |            |                |  |

**Notice of Qualifying Event (see below)**

**Medical Coverage**  Enroll  Terminate

**Reason**  Married  Domestic partnership established/registered  
 Loss of dependent status through divorce, legal separation, or termination of a qualified domestic partnership (please provide new address above)  
 Other (explain) \_\_\_\_\_  
 Date of qualifying event \_\_\_\_\_

**Are you 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 your Medicare card to this election form. **Part B (medical)**  Yes  No If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?**  Yes  No If yes, effective date \_\_\_\_\_

**Are you enrolled in Medicaid with creditable coverage?**  Yes  No

**Are you receiving Medicare disability?**  Yes  No If yes, effective date \_\_\_\_\_  
 If yes, attach a copy of your Social Security Disability Award letter.

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

|  |                        |                            |  |  |
|--|------------------------|----------------------------|--|--|
| <b>1</b>                               | Relationship           | Last name                  | First name   | Middle initial   |
|  | Social security number | Date of birth (mm/dd/yyyy) | Sex<br><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> |
| Address (if different from subscriber) |                        | City                       | State  | ZIP Code   |

**Notice of Qualifying Event (see below)**

**Medical Coverage**  Enroll  Terminate

**Reason:**  Loss of student status  Married  Other (explain) \_\_\_\_\_  
 Loss of dependent status through divorce, legal separation, or termination of a qualified domestic partnership  
 Attained age that is no longer eligible for PEBB coverage  
 Date of qualifying event \_\_\_\_\_

**Are you 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 your Medicare card to this election form. **Part B (medical)**  Yes  No If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?**  Yes  No If yes, effective date \_\_\_\_\_

**Are you enrolled in Medicaid with creditable coverage?**  Yes  No

**Are you receiving Medicare disability?**  Yes  No If yes, effective date \_\_\_\_\_  
 If yes, attach a copy of your Social Security Disability Award letter.

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

|  |                        |                            |  |  |
|--|------------------------|----------------------------|--|--|
| <b>2</b>                               | Relationship           | Last name                  | First name   | Middle initial   |
|  | Social security number | Date of birth (mm/dd/yyyy) | Sex<br><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> |
| Address (if different from subscriber) |                        |                            | City   | State  |
| ZIP Code                               |                        |                            |  |  |

**Notice of Qualifying Event (see below)**

**Medical Coverage**  Enroll Reason: \_\_\_\_\_  
 Terminate  Loss of student status  Married  Other (explain) \_\_\_\_\_  
 Loss of dependent status through divorce, legal separation, or termination of a qualified domestic partnership  
 Attained age that is no longer eligible for PEBB coverage  
 Date of qualifying event \_\_\_\_\_

**Are you 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 your Medicare card to this election form. **Part B (medical)**  Yes  No If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?**  Yes  No If yes, effective date \_\_\_\_\_

**Are you enrolled in Medicaid with creditable coverage?**  Yes  No

**Are you receiving Medicare disability?**  Yes  No If yes, effective date \_\_\_\_\_  
 If yes, attach a copy of your Social Security Disability Award letter.

**Section 4: Additions or Changes** Check all that apply.

**Retiree changed:**  Name  Address  Medical plan  Dental plan

**Change in family status:**  
 **Adding a spouse or qualified domestic partner**  
 If adding a spouse, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.  
 If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Domestic Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form.  
 **Adding family member 1** (from Section 3)  **Adding family member 2** (from Section 3)

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

Contact plans for more information; their addresses are shown at the end of this form.

|  |   |
|--|---|
| <input type="checkbox"/> Aetna Public Employees Plan of Washington | <input type="checkbox"/> Medicare Supplement Plan E, administered by Premera Blue Cross |
| Group Health Cooperative   | <input type="checkbox"/> Medicare Supplement Plan J, administered by Premera Blue Cross |
| <input type="checkbox"/> Group Health Classic ‡                    | PacifiCare of Washington, Inc.  |
| <input type="checkbox"/> Group Health Value ‡                      | <input type="checkbox"/> Secure Horizons Classic ‡                                      |
| Kaiser Foundation Health Plan of the Northwest                     | <input type="checkbox"/> Secure Horizons Value ‡  |
| <input type="checkbox"/> Kaiser Permanente Classic ‡               | <input type="checkbox"/> Uniform Medical Plan   |
| <input type="checkbox"/> Kaiser Permanente Value ‡                 |   |

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

**Section 6: Dental Plan Selection** Check only one.

**If I select dental coverage for myself, all of my covered family members will also have dental coverage for at least 2 years.**  
 Contact plans for more information; their addresses are shown at the end of this form.

|   |   |
|---|---|
| <p><b>Preferred Provider Organization</b></p> <input type="checkbox"/> Uniform Dental Plan (Group #3000)<br>(may receive services from any provider) <p><b>Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.</b></p> | <p><b>Managed Care Plans</b></p> <input type="checkbox"/> DeltaCare, administered by Washington Dental Service (Group #3100)<br>Dentist name or clinic code _____<br>(must receive services from DeltaCare provider) <input type="checkbox"/> Willamette Dental of Washington, Inc.<br>Clinic location _____<br>(must receive services from Willamette Dental Group Provider) |
|---|---|

**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 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. Application for Retiree Term Life Insurance must be made at the time of retirement. The cost is \$2.19 per month regardless of age.

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

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

Beneficiary \_\_\_\_\_ Beneficiary's SSN \_\_\_\_\_

Relationship to retiree \_\_\_\_\_ Beneficiary's date of birth \_\_\_\_\_

Beneficiary's address \_\_\_\_\_

## Section 8: Authorization for Enrollment and/or Premium

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.)

## 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 I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Benefits Services 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 calendar years.

If I or my family members choose to defer medical/dental, I understand I can re-enroll within 60 days of adding a new family member, losing other health coverage (with proof of continuous enrollment), or during the annual open enrollment period. If I defer enrollment for myself, I also defer enrollment for my family members.

We can defer enrollment in a PEBB health plan for:

- Comprehensive, employer-sponsored coverage
- Creditable Medicare/Medicaid coverage
- Federal retiree coverage (may only re-enroll in PEBB health plan[s] one time)

If I die, my 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.

**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](http://www.hca.wa.gov).

Retiree signature \_\_\_\_\_ Date \_\_\_\_\_



### Return form to:

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

**Be sure to sign and date this form.**

**Note:** If you or your family members are entitled to Medicare, you must be enrolled in **Medicare Parts A and B**. If you haven't done so already, please send a copy of the Medicare card(s) along with this form.

**Visit our Web site at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)**

### 2008 PEBB MEDICAL CONTRACTORS

**Aetna Public Employees Plan of Washington**, P.O. Box 14089, Lexington, KY 40512-4089

**Group Health Cooperative**, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233

**Kaiser Foundation Health Plan of the Northwest**, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099

**PacifiCare of Washington, Inc.**, 7525 SE 24th Street, Suite 200, P.O. Box 9005, Mercer Island, WA 98040-9005

**Premera Blue Cross**, P.O. Box 327, Seattle, WA 98111-0327

**Uniform Medical Plan**, P.O. Box 34850, Seattle, WA 98125-1850

### 2008 PEBB DENTAL CONTRACTORS

**DeltaCare, administered by Washington Dental Service**, 9706 Fourth Avenue NE, Seattle, WA 98115-2157

**Uniform Dental Plan**, 9706 Fourth Avenue NE, Seattle, WA 98115-2157

**Williamette Dental of Washington, Inc.**, 11241 Slater Ave. NE, Kirkland, WA 98033