

Section 5: ADULT DEPENDENT AUTHORIZATION FOR USE OR DISCLOSURE

I authorize the use or disclosure of personal health information about me as described in Section 6. I understand that this authorization is voluntary and I may cancel it at any time as described in Section 6. I understand that the same strict confidentiality standards that apply to my medical records under the Health Insurance Portability and Accountability Act (HIPAA) also apply to my health coverage records, and will not be shared with my employer or any other participants.

I authorize the Health Care Authority to provide information about me to _____ (print name of parent or guardian) for the purpose of eligibility, enrollment, and billing issues.

Section 6: ADULT DEPENDENT—IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time by notifying the Health Care Authority (HCA) in writing. The cancellation will not affect any information either received or given by the Health Care Authority before they received the cancellation notice. This authorization will automatically expire at the end of my participation in the PEBB Program.
- I may see a copy of this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my eligibility or enrollment, or as allowed by law.
- The person I authorize to receive information about me might share it with another person or organization. I have the right to ask the Health Care Authority to ensure that their employees do not share information about me with anyone other than the person noted above without my further authorization. Exceptions may include people or organizations needed to determine my eligibility and enrollment, or as allowed by law.

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.

Adult dependent's signature _____ Date _____

Please sign and date this form.

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

or fax to: 360-923-2608

If payment enclosed, return to: Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

Make checks payable to Washington State Treasurer.

2009 Monthly Premiums for Adult Dependents

Medical Plans	Aetna Public Employees Plan	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Uniform Medical Plan
Subscriber only	\$513.44	\$508.50	\$426.16	\$476.60	\$433.88	\$427.25

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Uniform Dental Plan	Willamette Dental	Dental Plans Dental Only	DeltaCare, administered by Washington Dental Service	Uniform Dental Plan	Willamette Dental
Subscriber only	\$37.19	\$41.69	\$37.03	Subscriber only	\$43.28	\$47.78	\$43.12

2009 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 34850, Seattle, WA 98124-1850
1-800-762-6004 or TTY 1-888-923-5622

2009 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Ave. NE, Seattle, WA 98115-2157 | 1-800-650-1583

Uniform Dental Plan, 9706 Fourth Ave. NE, Seattle, WA 98115-2157 | 1-800-537-3406

Willamette Dental of Washington, Inc., 11241 Slater Ave. NE, Kirkland, WA 98033 | 1-800-360-1909