Washington State Health Care Authority
Public Employees Benefits Board

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.)*

- ❑ Name
- ❑ Address
- ❑ Medical plan
- ❑ Dental plan
- ❑ Adding a spouse due to marriage or a Washington State-registered domestic partner
- ❑ 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.)
- ❑ Adding newly acquired child(ren) due to guardianship, marriage, or Washington State-registered domestic partnership
- ❑ Adding a dependent due to court order or medical support order (attach copy of court order or medical support order)
- ❑ Loss of other comprehensive group coverage
- ❑ Change in employment status
- ❑ 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: ______________________
  ____
- ❑ Terminating a dependent's coverage due to death
- ❑ Terminating a dependent's coverage due to loss of eligibility for PEBB coverage
- ❑ Other (explain) ______________________

Date of event ______________________

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 ❑ M ❑ 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 ❑ Enroll ❑ Waive: date effective______________________

Dental Coverage ☒ Enroll (Dental may not be waived.)

If waiving, see Section 6.
Note: If you waive coverage, you cannot enroll your eligible dependents in medical (except for adult dependents).

(continued on next page)

Agency name	Agency/subagency	Ins. effective date	Hire date

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 ❑ M ❑ F

Street address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	

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	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ 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 from medical: effective date ______________________
Reason ____

Dental Coverage ❑ Enroll ❑ Disenroll from dental: effective date ______________________
Reason ____

B

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ 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 from medical: effective date ______________________
Reason ____

Dental Coverage ❑ Enroll ❑ Disenroll from dental: effective date ______________________
Reason ____

C

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ 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 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